93-865

No.

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1993

BLUE CROSS AND BLUE SHIELD OF ALABAMA,

Petitioner,

vs.

UNITED STATES OF AMERICA,

Respondent.

Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

Whether, in erroneously interpreting 38 U.S.C. § 1729, the courts below imposed extracontractual burdens upon Blue Cross by effectively changing the supplemental nature of the C Plus Medicare supplemental contracts in violation of Blue Cross's Fifth Amendment-protected right to contract?

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BLUE CROSS AND BLUE SHIELD OF ALABAMA,

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UNITED STATES OF AMERICA,

Respondent.

Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

PETITION FOR WRIT OF CERTIORARI

The petitioner, Blue Cross and Blue Shield of Alabama ("Blue Cross"), by and through its attorney Fournier J. Gale, III, states the following in support of its Petition for Writ of Certiorari ("the Petition") to the United States Court of Appeals for the Eleventh Circuit:

DECISIONS BELOW

The decision of the District Court is captioned as *United States of America v. Blue Cross and Blue Shield of Alabama* and is reported at 791 F. Supp. 288 (N.D. Ala. 1992).

The decision of the Eleventh Circuit is captioned as *United States of America v. Blue Cross/Blue Shield of Alabama* and is reported at 999 F.2d 1542 (11th Cir. 1993).

STATEMENT OF JURISDICTION

(i) On September 8, 1993, the Eleventh Circuit entered its opinion affirming the District Court's entry on May 13, 1992 of a declaratory judgment in favor of the United States.

(ii) Blue Cross's petition for rehearing was denied by the Eleventh Circuit on October 15, 1993.

(iii) This is not a cross petition.

(iv) This Court has jurisdiction over this action pursuant to 28 U.S.C. § 1254. This Petition is filed within the time period established by this Court's Rule 13.4.

STATUTORY AND CONSTITUTIONAL PROVISIONS INVOLVED

The primary statutes relevant to the disposition of this case are: 38 U.S.C. § 1729 and 42 U.S.C. § 1395ss. Because these statutes are lengthy, they are set forth in the Appendix to this Petition.

The constitutional provision relevant to this case is the Due Process Clause of the Fifth Amendment to the Constitution, which Amendment provides in full:

> No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval

> forces, or in the Militia, when in actual service in time of War or public danger; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

STATEMENT OF THE CASE

The United States filed suit against Blue Cross in the United States District Court for the Northern District of Alabama seeking recovery of the costs of medical care rendered to eight Medicare-eligible veterans at various Veterans Administration ("VA") hospitals. The District Court had jurisdiction over the action pursuant to 28 U.S.C. § 1345.

Each named veteran received non-emergency medical services for a non-service connected disability at a VA hospital or medical center while covered under a C Plus Medicare supplement contract ("C Plus contract") issued by Blue Cross. The language of the C Plus contracts in existence between January 1, 1986, and January 1, 1990, the relevant time period during which the named veterans received medical services at the VA hospitals, remained virtually unchanged. The purpose of the C Plus coverage, as stated in the contract itself, is to supplement the amounts Medicare pays for some hospital, medical and surgical services:

> Before actually setting out the benefits, we would like to go into a little more detail about how Medicare and this Contract work together to protect you. . . .
>
> The Medicare deductible is that amount of healthcare charges the law requires you to pay before you begin to receive Medicare benefits.

> Co-insurance is that portion of your expenses for certain medical services that the law requires you to pay even after benefits begin. Your Blue Cross and Blue Shield hospital and Medicare coverage pays for the Medicare deductible and the co-insurance that you would otherwise have to pay yourself.
>
> Medicare deductible and co-insurance amounts change from time to time. When they do, our benefits under this contract will automatically change with them. . . .
>
> Your Medicare coverage always pays first. In order to collect these benefits, be sure to follow the instructions in your Medicare Handbook. Then, if you still have expenses left unpaid, your coverage under this Contract may pay them.

The controlling language of the C Plus contracts clearly states and establishes the Medicare supplemental nature of the policies, and even provides for automatic amendment of the policies whenever the Medicare deductibles and co-insurance amounts are altered. Moreover, the C Plus Medicare supplement policy, by its terms, is inextricably tied to Medicare's pre-determination of the applicable benefit payments allowed under the Medicare program.

Although each veteran named in the complaint was Medicare-eligible, neither the veterans nor the VA hospitals submitted any claim to Medicare for coverage for the costs incurred for any treatments received at the VA hospitals. The VA hospitals did, however, submit claims for the subject costs to Blue Cross. Those claims were denied because the veterans themselves were not entitled to benefits under the C Plus policies based, among other

things, on the fact that coverage under the contracts is secondary to Medicare, the VA hospitals are not "participating hospitals" under the terms of the policies defining covered medical costs, and no Medicare benefits determination was made for the services at issue. The veterans were not themselves required to pay for any services they received at the VA hospitals.

On appeal, the Eleventh Circuit affirmed the declaratory judgment entered by the District Court in favor of the United States. The underlying facts in this case were undisputed, and the parties agreed to disposition of the case upon cross-motions for summary judgment. Both the District Court and the Eleventh Circuit erroneously interpreted and applied the statutes involved in this proceeding, however. Thus, Blue Cross respectfully seeks this Court's remedy of the errors below.

REASON FOR GRANTING THE WRIT

THE COURTS BELOW, BY ERRONEOUSLY INTERPRETING 38 U.S.C. § 1729, IMPOSED EXTRA-CONTRACTUAL BURDENS UPON BLUE CROSS BY EFFECTIVELY CHANGING THE SUPPLEMENTAL NATURE OF THE C PLUS MEDICARE SUPPLEMENT CONTRACTS IN VIOLATION OF BLUE CROSS'S FIFTH AMENDMENT-PROTECTED RIGHT TO CONTRACT.

The C Plus contracts require that non-emergency medical services be rendered at a Medicare-participating hospital before coverage under the policies is triggered. The Circuit Court below held that this "participating hospital" provision in Petitioner's C Plus contracts "clearly operates 'to prevent recovery or collection by the United States' in contravention of 38 U.S.C. § 1729 (f)." *United States v. Blue Cross/Blue Shield of Alabama,* 999 F.2d 1542, 1546 (11th Cir. 1993). Further explaining its decision, the Circuit Court noted that, although the "Medigap policies do not

explicitly discriminate against the United States, a contractual provision that operates to prevent recovery by the United States . . . is prohibited by the statute even where the discrimination is not apparent from the face of the policy." *Id.* The Court then concluded that "the operation of this Medigap provision would prevent recovery by VA hospitals. . . [while] it would almost always allow recovery to private hospitals because virtually all private hospitals would qualify as participating hospitals." *Id.* The United States is not entitled to recover any amounts allegedly owed to the veterans under the C Plus policies pursuant to Section 1729, because the veterans themselves are not so entitled, based on the operation of generally applicable conditions precedent which underlie any benefits determination under the C Plus contracts, regardless of the public or private nature of the facility rendering the subject services.[1]

A. Blue Cross's Duties Are Established by the Terms of its Contract.

The C Plus policies at issue in this case are governed by the provisions of 42 U.S.C. § 1395ss. The purpose behind Medicare supplemental policies is to provide reimbursement for Medicare charges for which an individual would be personally liable because of deductibles, coinsurance amounts, or other Medicare-imposed limitations. 55 Fed. Reg. 48695 (1990) (to be codified at 32 C.F.R.

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1. Blue Cross continues to contend before this Court that the C Plus policies are not "health plan contracts" within the scope of 38 U.S.C. §1729; thus, the alleged discriminatory impact of the policies as "health plan contracts" should never be reached. Because the courts below assumed the contracts fell within the purview of the statute, however, Blue Cross will focus, for the sake of argument within this Petition, and without waiver of its remaining arguments before the lower courts, on the failure of Section 1729 to trigger liability under these policies even if they are considered to be included in the statutorily-defined third party payors.

pt. 220). These "Medigap" policies thus are designed to fill specific, statutorily-prescribed gaps in the Medicare benefit structure. By offering the Medigap contract to its Medicare-eligible subscribers, Blue Cross offers to pay, in consideration for premiums collected, amounts for which the insured would otherwise be liable. In other words, the Medigap policy pays benefits in the event (and to the extent set forth in the C Plus contracts) that the insured's out-of-pocket cost is created by the Medicare statutes as an adjunct to receipt of Medicare covered services. This obligation to pay Medicare-derived costs is the essence of the Medigap contract.

In reaching its decision that the Medigap policy at issue here discriminates against the United States, the Circuit Court overlooked this underlying purpose of the C Plus contract, which is to pay Medicare costs for which a Medicare-eligible individual would otherwise be personally liable. The purpose of the contract is not to pay any and all medical costs incurred, and it is not to pay costs not associated with concomitantly paid Medicare benefits.

Both courts below erroneously concluded that the condition precedent contained in the C Plus contract, requiring that services be provided by a Medicare-participating hospital, was a mere formality upon which Blue Cross conditioned payment under the C Plus policies. Because the essence of the C Plus contract is to provide supplementary payment of Medicare-derived costs, however, any requirement that Blue Cross pay for health services incurred outside the realm of the Medicare statutes in fact imposes a duty upon Blue Cross that was not contractually assumed when Blue Cross offered the C Plus contract in January of 1986, prior to the amendment of 38 U.S.C. § 1729 at issue in this proceeding. 38 U.S.C.A. § 1729, Historical and Statutory Notes (1991).

The Circuit Court held that "[i]n virtually all cases, because VA hospitals may not recover expenses from Medicare, 38 U.S.C.

§ 1729(i)(1)(a), the policies would prevent reimbursement to the United States." *United States v. Blue Cross/Blue Shield of Alabama*, 999 F.2d 1542, 1546 (footnote omitted). Blue Cross has never argued that, merely because Medicare is not required to pay the VA, the C Plus policies are not triggered. Rather, Blue Cross has attempted to emphasize that, because the C Plus insurance policy is itself a Medicare supplemental policy, the unambiguous provisions of the C Plus contract require a preliminary Medicare benefits determination before coverage is owed to the policyholder. Thus, the condition precedent at issue in this case is entirely consistent with, and in fact derived from, the *federal* statute from which Medicare supplemental policies originated. 42 U.S.C. § 1395ss(g)(1) (Supp. 1993).

Both courts below mistakenly accepted the fallacious argument asserted by the United States that Blue Cross designed its C Plus contracts to avoid payment to the Veterans Administration. This is not the case. The condition precedent contained in the C Plus contracts is narrowly tailored to implement Blue Cross's stated contractual purpose and obligation; that is, the payment of Medicare expenses that would otherwise be borne by the Medicare participant himself. The purpose and language of these C Plus contracts originated long before Congress amended 38 U.S.C. § 1729 to allow for reimbursement of the VA by a third party. Any perceived discriminatory effect of the C Plus contracts that would prevent recovery by the VA is the sole and unavoidable result of the federal statutory scheme which creates Medicare and governs the issuance of Medicare supplemental policies such as the C Plus contracts. The Medigap contractual benefits are inextricably intertwined with, and dependent upon, the prior determination of the insured's entitlement to Medicare benefits.

By way of analogy, the C Plus contract does not discriminate against the United States any more than would an accidental death policy. Each type of policy insures against a specific danger. The

Medigap policy insures against costs associated with the Medicare program. An accidental death policy insures against death by accidental means. Just as the insurance company issuing the accidental death policy would not be liable to the government for the death of its insured by natural means, so Blue Cross is not liable to a veteran (or the Veterans Administration) for non-Medicare related costs. In other words, the VA would be equally unjustified in seeking benefits from Blue Cross under the C Plus policies for either the accidental deaths of the named individuals or for services rendered to them for which Medicare provides no coverage: the applicable trigger under the C Plus contract is never pulled in either instance. Blue Cross, of course, did not issue an accidental death policy. Blue Cross also did not issue a general health insurance policy.[2] It issued a limited, supplemental policy to assist its Medicare-eligible policyholders in protecting themselves against the costly gaps in the Medicare system: gaps which these veterans never had to fill for the services at issue, which were rendered without cost by the VA facilities. The decisions entered by the courts below would require Blue Cross to make payments not contemplated by the contracting parties and effectively place Blue Cross in the position of reimbursing the government for the expenses of health care provided to veterans who are themselves

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2. Blue Cross invites this Court to examine the decision in *John Hancock Property & Casualty Insurance Company v. Blue Cross and Blue Shield of Michigan, et al.*, 471 N.W.2d 541 (Mich. 1991). At issue in *John Hancock* was whether the medical expenses incurred by two Medicare supplement policy subscribers injured in an automobile accident were covered under their supplemental policies. The court held that such expenses were excluded "because Medicare does not provide coverage for automobile accident medical expenses covered by automobile insurance. [Medicare supplemental] policies, only supplementing Medicare, were not written to fill that particular gap in the federal program." *Id.* at 545. This holding supports the precise argument asserted by Blue Cross in this case: the United States is precluded from recovering under the C Plus policies because the C Plus policies pay only supplemental to Medicare. The C Plus policies are Medicare gap fillers, not Medicare surrogates.

not entitled to recover under the Blue Cross C Plus policies. This result is clearly contrary to the provisions of 38 U.S.C.§ 1729.

B. The C Plus Policies Do Not Discriminate.

The Court of Appeals held that the participating hospital provision "while not discriminatory in explicit terms, clearly operates 'to prevent recovery or collection by the United States' in contravention of 38 U.S.C. 1729(f)." *United States v. Blue Cross/ Blue Shield of Alabama,* 999 F.2d 1542, 1546 (11th Cir. 1993). In reaching this conclusion, the Court relied upon the fact that Alabama's private general hospitals "all participate in Medicare." *Id.* This fact, in and of itself, is not evidence of discrimination against the United States.[3] Such a conclusion is analogous to

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3. Moreover, the lower court's finding that, at a certain point in time, all Alabama private hospitals participated in Medicare, by no means dictates that such a situation will endure. *See* 42 U.S.C. § 1395cc(b)(2) (1992) ("[the] secretary . . . may refuse to renew or may terminate such an agreement" for non-compliance with the terms of the agreement or with the Medicare statutes); *Schwartzberg v. Califano,* 453 F. Supp. 1042, 1046 (S.D.N.Y. 1978) (upholding non-renewal of Medicare participation agreement of private health care facilities for violations of statutes and agreement). Case law decided under § 1395cc establishes that private, non-Medicare participating facilities do exist. *See, e.g., Splawn v. Schweiker,* 545 F. Supp. 916, 917 (N.D. Tex. 1982) (Upholding denial of reimbursement to Medicare participant who obtained psychiatric services at non-Medicare participating private hospital). Indeed, the very existence of the federal statute requiring that providers enter into participation agreements in order to participate in the Medicare program and establishing the rigorous standards under which such agreements will be created and maintained evidences the transitory nature of status as a Medicare participating facility. *See* 42 U.S.C § 1395cc(a)(1) (1992); *e.g., Monterey Life Systems v. United States,* 635 F.2d 821, 826 (Ct. Cl. 1980), *Homan & Crimen, Inc. v. Harris,* 626 F.2d 1201, 1209 (5th Cir. 1980), *cert. denied,* 450 U.S. 975, 101 S. Ct. 1506 (1981) (recognizing mandatory requirement of participation agreement for receipt of Medicare payments). Dramatic changes proposed for the health care industry as a whole likewise may circumscribe the current broad base of Medicare participation.

(Cont'd)

finding that accidental death policies discriminate against the United States because they pay benefits only upon the accidental death of the insured. Simply put, the C Plus Medigap policies are intended to insure against certain Medicare-related expenses otherwise borne by the recipient of the covered services. If no Medicare-covered expenses are incurred, there is no right to payment under the supplemental policy. Non-emergency, Medicare-covered expenses will not be obtained at a non-participating hospital, whether public or private. The Circuit Court's decision effectively confers a preferred status upon the VA facilities vis-a-vis the private hospitals, in that the government facilities would be allowed to disregard contractual requirements imposed on private hospitals, including the central criterion of a Medicare benefits determination.

Section 1729(f) provides that "[n]o provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section." Section 1729(a)(1) allows recovery by the United States of the reasonable costs of care or services that the veteran would be eligible to receive "if the care or services had not been furnished by a department or agency of the United States." Section 1729(a)(2)(D) specifies that the United States may recover costs of care and services incurred by a veteran: (1) for a non-service connected disability; *and* (2) *if* the veteran *is entitled to payment of the expenses of care* under a health plan contract. Thus, putting the subsections together, no contract shall operate to prevent recovery by the United States under this section; however, the United States is entitled to recover under a health plan

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Additionally, the absence of non-participating private hospitals in Alabama is irrelevant: C Plus policyholders receive or are denied coverage in accordance with the same generally applicable contractual provisions whether they are treated in public hospitals or private, in Alabama or Alaska. The lower court's "snapshot" finding of the status of Alabama hospitals thus bears no weight in this Court's consideration of the question before it.

contract only *to the extent* the veteran could receive benefits, 38 U.S.C. § 1729(a)(1), and only *if* the veteran is entitled to "payment of the expenses of care." *Id.*, § 1729(a)(2)(D)(ii). Upon a close examination of the statute, it is clear that the courts below omitted from consideration a vital condition upon which the government's alleged right of recovery is based: the veteran's own entitlement to payment of the expenses of care.

In sum, because the veterans at issue were not entitled to "payment of the expenses of care" under the provisions of the C Plus contract, the contract did not operate in a discriminatory manner to prevent recovery by the government. Indeed, any different analysis would transform Section1729 into a statutory quagmire, ensnaring any health-related contract and mandating payment to the United States in circumstances completely external to the realm of contractual responsibility negotiated between the insured and the insuror. This was not Congress's intent.

C. The Interpretation of § 1729 by the Courts Below Impairs Blue Cross's Right to Contract.

Implicit in the Circuit Court's opinion is the conclusion that enactment of 38 U.S.C. § 1729 preceded the C Plus contract at issue in this case. *United States v. Blue Cross/Blue Shield of Alabama*, 999 F.2d 1542, 1547 (11th Cir. 1993). As was called to the attention of both courts below, the C Plus contracts issued between January 1, 1986 and 1990[4] were virtually unchanged. Yet, the Circuit Court's decision admonishes Blue Cross for "enter[ing] into contracts which violate existing law, then claim[ing] that the enforcement of that law infringes upon its right to contract." *Id.* In fact, Blue Cross wrote and issued the C Plus contract before Congress amended § 1729, effective April 7, 1986, to allow for

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4. The years during which the veterans named in the Complaint received services at the VA hospital for which recovery is sought by the government.

payment under health plan contracts to the government. 38 U.S.C.A. § 1729, Historical and Statutory Notes (1991). Then, as demonstrated by the legislative history surrounding the 1986 amendments to § 1729, the Senate Committee on Veterans' Affairs devised the amendments as a fund-raising measure solely to reduce budget outlays through collection of funds from private payers to subsidize the costs of VA health care facilities by $300,000,000 in fiscal year 1986, by $400,000,000 in 1987, and by $450,000,000 in 1988. S. Conf. Rep. No. 146, 99th Cong., 1st Sess., at 556.

This Court has long recognized that individuals have a property interest in contracts and that the taking of contractual rights can constitute the deprivation of property without due process in violation of the Fifth Amendment. *Lynch v. United States*, 292 U.S. 571, 579, 54 S. Ct. 840, 843 (1934). As this Court has noted, "[t]he purpose of forbidding uncompensated takings of private property for public use is 'to bar government from forcing some people alone to bear public burdens which, in all fairness and justice, should be born by the public as a whole.' " *Connolly v. Pension Benefit Guarantee Corporation*, 475 U.S. 211, 227, 106 S. Ct. 1018, 1027 (1986) (quoting *Armstrong v. United States*, 364 U.S. 40, 49, 80 S. Ct. 1563, 1569 (1960).

In analyzing takings clause cases, this Court has warned against "the development of any set formula for identifying a 'taking' forbidden by the Fifth Amendment, and [has] relied instead on *ad hoc*, factual inquiries and the circumstances of each particular case." *Connolly*, 475 U.S. at 224. The Court has identified, however, "three factors which have 'particular significance': (1) 'the economic impact of the regulation on the claimant;' (2) 'the extent to which the regulation has interfered with distinct investment-backed expectations;' and (3) 'the character of the governmental action.' " *Connolly*, 475 U.S. at 224-25 (quoting *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986, 1005, 104 S. Ct. 2862, 2874 (1984)). In the instant case, the economic impact

of the statute upon Blue Cross is substantial. Section 1729 (f), and the lower court's interpretation thereof, have fundamentally changed the very nature of Blue Cross's C Plus policy, including the premium rate structure utilized to date by Blue Cross. Indeed, enforcement of Section 1729 against Blue Cross imposes significant economic burdens that were not assumed by Blue Cross when it formulated the C Plus contract as a service to Medicare recipients. Finally, in adopting the amendments to § 1729, Congress has forced "some people alone to bear public burdens which, in all fairness and justice, should be born by the public as a whole," *Connolly*, 475 U.S. at 227, simply to allow the diversion of federal funds to other areas. Thus, it is clear, in this case, that "fairness and justice [should] require the public, rather than the [participants in the C Plus policies or Blue Cross] to shoulder the responsibility" for funding the federal VA hospitals. *Id.*

The interpretation of the C Plus policies sanctioned by the courts below imposes a contractual obligation upon Blue Cross that was not sanctioned by existing law, that was not bargained for by the parties, and that is expressly prohibited by the due process clause of the Fifth Amendment, which protects the freedom to enter into valid, enforceable contracts upon terms mutually acceptable to the contracting parties. To give effect to such an interpretation would, in essence, be to rewrite the policies to create an overwhelming administrative and financial burden upon Blue Cross in derogation of the contracted-for terms of the C Plus policies and, indeed, in derogation of the Medicare statutes that create and ultimately govern the policies. Because there would be no Medicare determination, the result for Medicare supplemental policy issuers would be a substantially increased administrative burden, uncertain and speculative claims processing, and a far greater than anticipated or contractually-assumed claims experience. Moreover, this substantial financial burden would adversely affect all C Plus policyholders, including the veterans named herein, as Blue Cross accordingly will be forced to adjust its rates upward for these experience-rated C Plus policies.

CONCLUSION

For the reasons set forth above, Blue Cross prays that this Court issue a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit in order to review that court's application of 38 U.S.C. § 1729 to the terms of the C Plus contracts issued by Blue Cross. Alternatively, Blue Cross requests that the Court summarily reverse the Eleventh Circuit's decision.

Respectfully submitted,

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APPENDIX A — OPINION OF UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DATED SEPTEMBER 8, 1993

UNITED STATES of America,

Plaintiff-Appellee,

v.

BLUE CROSS/BLUE SHIELD OF ALABAMA,

Defendant-Appellant.

No. 92-6521.

United States Court of Appeals, Eleventh Circuit.

Sept. 8, 1993.

Fournier J. Gale, III, Maynard, Cooper, Frierson & Gale, Jayna Jacobson Partain, Birmingham, AL, for defendant-appellant.

Jack Selden, U.S. Atty., Jenny L. Smith, Birmingham, AL, Mary Jo Donahue, U.S. Dept. of Justice, Civil Div., Colette J. Winston, Washington, DC, for plaintiff-appellee.

Appeal from the United States District Court for the Northern District of Alabama.

Before BLACK and CARNES, Circuit Judges, and RONEY, Senior Circuit Judge.

Appendix A

RONEY, Senior Circuit Judge:

This is one of a number of cases across the country in which the United States seeks to recover from Blue Cross/Blue Shield medical insurance programs for the costs of medical care rendered to veterans in government hospitals. We affirm the district court's decision to grant the government's motion for summary judgment, and hold that any provision of the medigap insurance policies issued by Blue Cross/Blue Shield of Alabama (Blue Cross) that discriminates against the United States in the payment of benefits is contrary to 38 U.S.C. § 1729.

I

The material facts are not in dispute. Each veteran received medical care and treatment at VA hospitals in Alabama for non-service-connected disabilities. At the time of their medical care, each veteran was eligible for Medicare and was covered under a Blue Cross C Plus Medicare Supplemental (medigap) insurance policy[1]. Because the veterans were treated at VA hospitals, they

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1. The introduction to the policies states:

> As a person enrolled under Medicare, you probably know that Medicare has provisions that require you to pay a deductible amount and some amounts of co-insurance.
>
> The Medicare deductible is that amount of health care charges the law requires you to pay before you begin to receive Medicare benefits.
>
> Co-insurance is that portion of your expenses for certain medical services that the law requires you to pay even

(Cont'd)

were not required to pay for the services they received so they did not claim Medicare benefits. The VA hospitals submitted claims to Blue Cross based on the medigap policies but these claims were denied. The United States then gave the requisite statutory notice to the named veterans of its intent to sue, and filed this suit under 38 U.S.C. § 1729.[2]

The complaint filed by the United States sought recovery from Blue Cross for the costs of medical care rendered to eight[3] veterans, asserting that the Veterans Benefits Act, 38 U.S.C. § 1729, required Blue Cross to reimburse the VA for its services as if the care were rendered at a private hospital. After oral arguments on cross-motions for summary judgment, the district court entered a declaratory judgment, holding that the medigap policies were "health-plan contracts" as defined by the statute, and that the United States was entitled to recover from Blue Cross payment for the cost of services covered by the medigap policies. *United States v. Blue Cross & Blue Shield of Alabama,* 791 F.Supp. 288 (N.D.Ala.1992). This appeal followed.

This court reviews the district court's order granting summary

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> after benefits begin. Your Blue Cross and Blue Shield Hospital and Medicare Coverage pays for the Medicare deductible and the co-insurance that you would otherwise have to pay yourself.

2. 38 U.S.C. § 1729 provides that when a veteran is furnished medical services by the United States for a non-service-connected condition, the United States can recover the cost of such service under a health-plan contract if the veteran would be eligible to recover the cost had the services not been provided by the United States.

3. There were originally nine named veterans, but because one was covered under a policy issued by the Blue Cross of a state other than Alabama, the United States no longer seeks payment for the care rendered to that veteran.

judgment de novo. *Akins v. Snow,* 922 F.2d 1558, 1560 (11th Cir. *cert. denied,* ___ U.S. ___, 111 S.Ct. 2915, 115 L.Ed.2d 1079 (1991).

II

Blue Cross defends its denial of the claims by asserting that

first, the medigap policies are not covered under 38 U.S.C. § 1729 because they are not health-plan contracts as defined by the statute;

second, even if the policies are health-plan contracts, the United States may recover only the amount to which the policy holder would be entitled, which is nothing because the triggering factor, payment by Medicare, is prohibited by the statute, and the terms of the policies specifically exclude payment to hospitals, such as the VA hospitals, that do not participate in the Medicare program;

third, the interpretation asserted by the United States would work an unconstitutional impairment of the Fifth Amendment right to contract.

38 U.S.C. § 1729 purports to place a VA hospital on the same basis as a private hospital for the purpose of recovering under third-party insurance contracts. Section 1729(a)(1) provides:

> in any case in which a veteran is furnished care or services under this chapter for a non-service-connected disability . . . , the United States has the right to recover or collect the reasonable cost of such care or services (as determined by

> the Secretary [of Veterans Affairs]) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.

The United States may recover the costs of medical care incurred by a veteran "who is entitled to care (or payment of the expense of care) under a health-plan contract." 38 U.S.C. § 1729(a)(2)(D)(ii). A "health-plan contract" is defined as "an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid." 38 U.S.C. § 1792(i)(1)(A). The Medicare program is specifically excluded from the meaning of a health-plan contract. 38 U.S.C. § 1729(i)(1)(B).

These provisions allow the United States to recover the costs of care and services from a third party (other than Medicare) to the extent that the veteran or a private hospital would have received payment if the care and services had not been provided at a VA hospital. Contractual abrogation of this provision is prohibited by section 1792(f), which states that "[n]o law of any State or of any political subdivision of a State, and no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section."

Appendix A

A.

Are the medigap policies "health plan contracts"?

The medigap policies clearly are "health-plan contracts" within the meaning of the statute. "A health-plan contract need do only one of two things — provide health services or reimburse the expenses of such services." *United States v. Blue Cross & Blue Shield of Maryland,* 989 F.2d 718, 727 (4th Cir. 1993). The policies undoubtedly qualify as policies "under which . . . the expenses of [health] services are paid." 38 U.S.C. § 1729(i)(1)(A).

Although medigap policies are not listed as a type of policy excluded from the meaning of "health-plan contracts," Blue Cross argues that the exclusion for Medicare creates an exclusion for medigap policies as well.[4] The plain language of the exclusion refers only to Medicare. It does nothing to exclude from the definition of health-plan contracts those policies issued by private insurance companies such as Blue Cross as a supplement to Medicare benefits.

The legislative history of 38 U.S.C. § 1729 supports this conclusion. Discussing the Medicare exclusion, House Report No. 300 states: "In the event the veteran has both Medicaid and private health insurance, the private health insurance would be payable in accordance with its terms, but no reimbursement from Medicare or

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4. This exclusion reads:

> (B) Such term does not include—
>
> (i) an insurance program described in section 1811 of the Social Security Act (42 U.S.C. 1395c) or established by section 1831 of such Act (42 U.S.C. 1395j).

38 U.S.C. § 1729(i)(B).

Medicaid could be obtained by the VA or the private insurance company." House Rep. No. 300, 99th Cong., 1st Sess. 790 (1985), *reprinted in* 1986 U.S.C.C.A.N. 1248, 1265. The medigap policies issued by Blue Cross are health-plan contracts governed by the reimbursement and anti-discrimination provisions of § 1729. *Accord United States v. Capital Blue Cross,* 992 F.2d 1270 (3d Cir.1993).

B.

Is payment of medicare benefits a valid condition precedent?

Blue Cross next asserts that the United States may not seek reimbursement because a condition precedent to recovery under the policy (payment by Medicare) is statutorily prevented from occurring when the care is delivered by a VA hospital. The question here is whether such a provision violates 38 U.S.C. § 1729(f), which provides that no contract "shall operate to prevent recovery or collection by the United States under this section" and which is known as the anti-discrimination provision of the statute.

It is true that the medigap policies do not explicitly discriminate against the United States. A contractual provision that operates to prevent recovery by the United States, however, is prohibited by the statute even where the discrimination is not apparent from the face of the policy. *See United States v. State of Ohio,* 957 F.2d 231 (6th Cir.) *cert. denied,* ___ U.S. ___, 113 S.Ct. 75, 121 L.Ed.2d 40 (1992); *United States v. State of Maryland,* 914 F.2d 551 (4th Cir.1990); *United States v. State of New Jersey,* 831 F.2d 458 (3d Cir.1987).

The medigap policies issued by Blue Cross clearly operate to prevent recovery by the United States. In virtually all cases,

because VA hospitals may not recover expenses from Medicare, 38 U.S.C. § 1729(i)(1)(A), the policies would prevent reimbursement to the United States.[5] Alabama's private general hospitals, on the other hand, all participate in Medicare, *United States v. Blue Cross & Blue Shield of Alabama*, 791 F.Supp. 288, 289 n. 4 (N.D.Ala.1992), and therefore virtually always qualify for recovery under the medigap policies. As a practical matter, according to Blue Cross' interpretation of its medigap policies, the VA is denied recovery while private hospitals are not.

The anti-discrimination provision precludes Blue Cross from relying on the contractual exclusion from coverage for care provided at a hospital that does not participate in Medicare. The policies provide that inpatient hospitalizations, except for emergency care, are covered only if the care is received in a "participating hospital," which is defined as "one that participates in Medicare under an agreement with the Department of Health and Human Services." Since VA hospitals do not bill Medicare for the services they render to Medicare-eligible veterans, they are "non-participating hospitals," and their services are excluded from coverage under Blue Cross' medigap policies.

Blue Cross' participating hospital provision, while not discriminatory in explicit terms, clearly operates "to prevent recovery or collection by the United States" in contravention of 38 U.S.C. § 1729(f). While the operation of this medigap provision would prevent recovery by VA hospitals, which are prohibited by law from participating in Medicare, 42 U.S.C. §§ 1395f(c) &

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5. In all likelihood, the VA is prohibited from recovering from Medicare to avoid the unnecessary transfer of federal funds when all the money is coming out of the same coffer. *See United States v. Blue Cross & Blue Shield of Maryland*, 989 F.2d 718, 726 n. 5 (4th Cir.1993).

1395n(d), it would almost always allow recovery to private hospitals because virtually all private hospitals would qualify as participating hospitals. This result constitutes discrimination against the United States in violation of 38 U.S.C. § 1729(f).

C.

Does an award to the United States violate a fifth amendment right to contract?

In an argument not addressed by the trial court, if made, nor by other reported opinions in similar litigation, Blue Cross contends that the relief requested by the United States would impair its Fifth Amendment right to contract. The right to contract is not without bound, however, but is confined by existing law. The application of a regulatory statute that is otherwise valid may not be defeated by private contracts. "If the regulatory statute is otherwise within the powers of Congress, therefore, its application may not be defeated by private contractual provisions." *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 224, 106 S.Ct. 1018, 1025, 89 L.Ed.2d 166 (1986). No argument has been made that Congress did not have the power to provide that the United States could not be discriminated against in the operation of such medical insurance plans. Blue Cross cannot enter into contracts which violate existing law, then claim that the enforcement of that law infringes upon its right to contract. The district court properly rejected Blue Cross' Fifth Amendment claim.

III

As a result of our holding, Blue Cross must determine eligibility for medigap coverage as though the veterans had received care from a private billing hospital which participated in

and received reimbursement through the Medicare program. Blue Cross must make a determination regarding coverage for those expenses Medicare would not have reimbursed. Our holding "does not mandate coverage; it merely prohibits an exclusion from recovery based on a *per se* rejection of a class of potential recipients (*i.e.*, veterans), but still permits [Blue Cross] to exercise discretion in determining eligibility on a case-by-case basis." *United States v. Blue Cross & Blue Shield of Maryland,* 989 F.2d 718, 725 (4th Cir.1993). The United States may pursue the veteran patients' claims under the medigap policies.

This decision brings Blue Cross/Blue Shield of Alabama in line with most of such programs that have dealt with this issue. We are told that the plans in 19 states and the District of Columbia all provide for reimbursement to the United States under medigap policies. *United States v. Capital Blue Cross,* 796 F.Supp. 144, 153 (M.D.Pa.1992), *aff'd,* 992 F.2d 1270 (3d Cir.1993). The plans have consistently lost in litigation involving the claims of the United States. *See United States v. Capital Blue Cross,* 992 F.2d 1270 (3d Cir.1993); *United States v. Blue Cross & Blue Shield of Maryland,* 989 F.2d 718 (4th Cir.1993).

AFFIRMED.

APPENDIX B — OPINION OF THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ALABAMA DATED MAY 13, 1992

UNITED STATES of America,

Plaintiff,

v.

BLUE CROSS AND BLUE SHIELD OF ALABAMA,

Defendant.

Civ. A. No. CV 91-L-0443-S.

United States District Court,
N.D. Alabama, S.D.

May 13, 1992.

Jack W. Selden, U.S. Atty., Jenny L. Smith, Asst. U.S. Atty., Birmingham, Ala., Stuart M. Gerson, I.N.S., Litigation Office, Civil Div., Washington, D.C., for plaintiff.

Fournier J. Gale, III, Jayna Jacobson Partain, Maynard Cooper Frierson & Gale, Birmingham, Ala., for defendant.

OPINION

LYNNE, Senior District Judge.

This action was submitted upon cross-motions for summary judgment upon the pleadings and undisputed facts. Pursuant to 38 U.S.C. § 1729, plaintiff sues to recover of defendant the reasonable costs of care or services furnished to the veterans named in the amended complaint[1] to the extent the veterans (or the

1. The name of James Wildes was deleted from the list of nine veterans (Cont'd)

provider of care or services) would be eligible to receive payment if the care of or services had not been furnished by a facility operated by the Department of Veterans Affairs, an agency of the United States.[2]

During the years 1987-1990 the eight veterans were furnished care and services at VA Hospitals in Birmingham, Montgomery, or Tuscaloosa, Alabama. Each was Medicare eligible and was an insured in a Blue Cross and Blue Shield of Alabama ("Blue Cross") C Plus Medicare Supplemental Contract, commonly known as a "Medigap" policy. The VA submitted a claim to Blue Cross for the cost of care and services received by each veteran but Blue Cross refused to pay any portion of the claims submitted.

Blue Cross responds that it is not obligated by the terms of its Medigap policy to pay any portion of the claims submitted by plaintiff because the care and services were rendered by a "non-participating hospital."[3] Its argument, bluntly stated, amounts to

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(Cont'd)
appearing in the Amended Complaint. All references to veterans herein describe veterans of the armed services whose physical or mental illnesses or disabilities were not connected.

2. The United States has complied with the notice requirement of 38 U.S.C. § 1729(b)(2)(B).

3. The introduction to the Blue Cross Medigap policy states:

> As a person enrolled under Medicare you probably know that Medicare has provisions that require you to pay a deductible amount and some amounts of coinsurance.
>
> The Medicare deductible is that amount of health care

(Cont'd)

this: If the care and services had been provided by a private general hospital which participates in Medicare,[4] we would have paid the Medicare deductible and some amounts of coinsurance. But since the VA hospital concerned does not participate in Medicare, we owe nothing.

It is true that VA hospitals do not participate in the Medicare program. It is also true that VA hospitals may not recover expenses for care and services from the Medicare program under Section 1729. Section 1729(i)(1)(B)(i)[5] expressly excludes Medicare from

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(Cont'd)

> charges the law requires you to pay before you begin to receive Medicare benefits.
>
> Coinsurance is that portion of your expenses for certain medical services that the law requires you to pay even after benefits begin. Your Blue Cross and Blue Shield Hospital and Medicare coverage pays for the Medicare deductible and the coinsurance that you would otherwise have to pay yourself.

4. It is noteworthy that every private general hospital in the State of Alabama participates in Medicare.

5. (i) For purposes of this section —

> (1)(A) The term "health-plan contract" means an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid.
>
> (B) Such term does not include —

(Cont'd)

the definition of "healthplan contract" that is set forth in Section 1729(i)(1)(A) evidently because Congress decided not to "rob Peter to pay Paul." However, despite distingenuous contentions to the contrary, it is obvious that the Blue Cross Medigap policy is a health plan contract. If the veterans had been rendered care and services in a participating hospital they would have been eligible to have received from the third party, Blue Cross, payment for the deductibles and coinsurance. Hence, under the provisions of 38 U.S.C. § 1729(a)(1),[6] the United States is entitled to recover therefor. This result flows ineluctably from the anti-discrimination provisions of 38 U.S.C. § 1729(f).[7]

The court disclaims any intention to rewrite the definition of a participating hospital in the Blue Cross Medigap policy. It simply

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(Cont'd)

> (i) an insurance program described in section 1811 of the Social Security Act (42 U.S.C. 1395c) or established by section 1831 of such Act (42 U.S.C. 1395j).

6. § 1729. Recovery by the United States of the cost of certain care and services

(a)(1) Subject to the provisions of this section, in any case in which a veteran is furnished care or services under this chapter for a non-service-connected disability described in paragraph (2) of this subsection, the United States has the right to recover or collect the reasonable cost of such care or services (as determined by the Secretary) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care of services had not been furnished by a department or agency of the United States.

7. (f) No law of any State or of any political subdivision of a State, and no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section or with respect to care or services furnished under section 1711(b) of this title.

holds that the cited statutory provisions compel the conclusion that care and services furnished to a non-service-connected veteran by a VA hospital must, as a matter of law, be deemed to have been furnished by a participating hospital in an action to recover benefits thereunder.

While plaintiff seeks both declaratory and monetary relief, the court has been presented with no facts which enable it to determine what portions of the claims filed with respect to the eight veterans are due to be paid.[8] Accordingly, the court will enter a declaratory judgment which it believes consistent with the rationales of *United States v. State of Ohio*, 957 F.2d 231 (6th Cir. 1992); *United States v. State of Maryland*, 914 F.2d 551 (4th Cir. 1990); and *United States v. State of N.J., Violent Crimes Comp. Bd.*, 831 F.2d 458 (3rd Cir. 1987).

DECLARATORY JUDGMENT

In conformity with the opinion of the Court filed contemporaneously herewith and attached hereto,

It is ORDERED, ADJUDGED and DECREED by the Court as follows:

38 U.S.C. § 1729 applies to Medicare supplemental ("Medigap") contracts.

Thus, under 38 U.S.C. § 1729, Blue Cross

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8. The adoption of a rigid formula that Blue Cross is required to pay only deductibles and co-payments in past, present and future cases to which this opinion applies would be misleading. In some cases C Plus contracts may contemplate payment of other benefits. The formula would either be too narrow or too broad.

and Blue Shield of Alabama (BCBS") is required to reimburse the Department of Veterans Affairs ("VA") for a portion of the cost of medical care and services received by veterans with non-service-connected disabilities at VA medical facilities who hold Medigap contracts with BCBS.

The only portion owed by BCBS is that which the veteran (or the provider of the care or services) would have been entitled to receive from BCBS if the medical care had been rendered in a non-government facility.

It is further ORDERED that each party is to bear its own costs.

APPENDIX C — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DENYING REHEARING FILED OCTOBER 15, 1993

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 92-6521

UNITED STATES OF AMERICA,

Plaintiff-Appellee,

versus

BLUE CROSS/BLUE SHIELD OF ALABAMA,

Defendant-Appellant.

On Appeal from the United States District Court for the Northern District of Alabama

ON PETITION FOR REHEARING

BEFORE: BLACK, and CARNES, Circuit Judges and RONEY, Senior Circuit Judge.

PER CURIAM:

The Petition for rehearing filed by appellant Blue Cross/Blue Shield of Alabama is denied.

ENTERED FOR THE COURT:

s/ Black, J.
United States Circuit Judge

APPENDIX D—STATUTORY PROVISIONS INVOLVED

38 U.S.C. § 1729

§ 1729. Recovery by the United States of the cost of certain care and services.

(a)(1) Subject to the provisions of this section, in any case in which a veteran is furnished care or services under this chapter for a non-service-connected disability described in paragraph (2) of this subsection, the United States has the right to recover or collect the reasonable cost of such care or services (as determined by the Secretary) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care of services had not been furnished by a department or agency of the United States.

(2) Paragraph (1) of this subsection applies to a non-service-connected disability —

(A) that is incurred incident to the veteran's employment and that is covered under workers' compensation law or plan that provides for payment for the cost of health care and services provided to the veteran by reason of the disability;

(B) that is incurred as the result of a motor vehicle accident to which applies a State law that requires the owners or operators of motor vehicles registered in that State to have in force automobile accident reparations insurance;

(C) that is incurred as the result of a crime of personal violence that occurred in a State, or a political

subdivision of a State, in which a person injured as the result of such a crime is entitled to receive health care and services at such State's or subdivision's expense for personal injuries suffered as the result of such crime;

(D) that is incurred by a veteran —

(i) who does not have a service-connected disability; and

(ii) who is entitled to care (or payment of the expenses of care) under a health-plan contract; or

(E) for which care and services are furnished before October 1, 1993, under this chapter to a veteran who —

(i) has a service-connected disability; and

(ii) is entitled to care (or payment of the expenses of care) under a health-plan contract.

(3) In the case of a health-plan contract that contains a requirement for payment of a deductible or copayment by the veteran —

(A) the veteran's not having paid such deductible or copayment with respect to care or services furnished under this chapter shall not preclude recovery or collection under this section; and

(B) the amount that the United States may collect or recover under this section shall be reduced by the appropriate deductible or copayment amount, or both.

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(b)(1) As to the right provided in subsection (a) of this section, the United States shall be subrogated to any right or claim that the veteran (or the veteran's personal representative, successor, dependents, or survivors) may have against a third party.

(2)(A) In order to enforce any right or claim to which the United States is subrogated under paragraph (1) of this subsection, the United States may intervene or join in any action or proceeding brought by the veteran (or the veteran's personal representative, successor, dependents, or survivors) against a third party.

(B) The United States may institute and prosecute legal proceedings against the third party if —

(i) an action or proceeding described in subparagraph (A) of this paragraph is not begun within 180 days after the first day on which care or services for which recovery is sought are furnished to the veteran by the Secretary under this chapter;

(ii) the United States has sent written notice by certified mail to the veteran at the veteran's last-known address (or to the veteran's personal representative or successor) of the intention of the United States to institute such legal proceedings; and

(iii) a period of 60 days has passed following the mailing of such notice.

(C) A proceeding under subparagraph (B) of this paragraph may not be brought after the end of the six-year period beginning on the last day on which the care or services for which recovery is sought are furnished.

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(c)(1) The Secretary may compromise, settle, or waive any claim which the United States has under this section.

(2)(A) The Secretary, after consultation with the Comptroller General of the United States, shall prescribe regulations for the purpose of determining the reasonable cost of care or services under subsection (a)(1) of this section. Any determination of such cost shall be made in accordance with such regulations.

(B) Such regulations shall provide that the reasonable cost of care or services sought to be recovered or collected from a third-party liable under a health-plan contract may not exceed the amount that such third party demonstrates to the satisfaction of the Secretary it would pay for the care or services if provided by facilities (other than facilities of departments or agencies of the United States) in the same geographic area.

(C) Not later than 45 days after the date on which the Secretary prescribes such regulations (or any amendment to such regulations), the comptroller General shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives the Comptroller General's comments on and recommendations regarding such regulations (or amendment).

(d) Any contract or agreement into which the Secretary enters with a person under section 3718 of title 31 for collection services to recover indebtedness owed the United States under this section shall provide, with respect to such services, that such person is subject to sections 5701 and 7332 of this title.

(e) A veteran eligible for care or services under this chapter

(1) may not be denied such care or services by reason of this section; and

(2) may not be required by reason of this section to make any copayment or deductible payment in order to receive such care.

(f) No law of any State or of any political subdivision of a State, and no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section or with respect to care or services furnished under section 1711(b) of this title.

(g)(1) There is established in the Treasury a fund to be known as the Department of Veterans Affairs Medical-Care Cost Recovery Fund (hereafter referred to in this section as the "Fund").

(2) Amounts recovered or collected under this section shall be deposited in the Fund.

(3) Sums in the Fund shall be available to the Secretary for the following:

(A) Payment of necessary expenses for the identification, billing, and collection of the cost of care and services furnished under this chapter, and for the administration and collection of payments required under section 1710(f) of this title for hospital care or nursing home care, under section 1712(f) of this title for medical services, and under section 1722A of this title for medications, including —

(i) the costs of computer hardware and software,

word processing and telecommunications equipment, other equipment, supplies, and furniture;

(ii) personnel training and travel costs;

(iii) personnel and administrative costs for attorneys in the Office of General Counsel of the Department and for support personnel of such office;

(iv) other personnel and administrative costs; and

(v) the costs of any contract for identification, billing, or collection services.

(B) Payment of the Secretary for reasonable charges, as determined by the Secretary, imposed for (i) services and utilities (including light, water, and heat) furnished by the Secretary, (ii) recovery and collection activities under this section, and (iii) administration of the Fund.

(4) Not later than January 1 of each year, there shall be deposited into the Treasury as miscellaneous receipts an amount equal to the amount of the unobligated balance remaining in the Fund at the close of business on September 30 of the preceding year minus any part of such balance that the Secretary determines is necessary in order to enable the Secretary to defray, during the fiscal year in which the deposit is made, the expenses, payments, and costs described in paragraph (3).

(h)(1) Subject to paragraph (3) of this subsection, the Secretary shall make available medical records of a veteran

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described in paragraph (2) of this subsection for inspection and review by representatives of the third party concerned for the sole purposes of permitting the third party to verify —

(A) that the care or services for which recovery or collection is sought were furnished to the veteran; and

(B) that the provision of such care or services to the veteran meets criteria generally applicable under the health-plan contract involved.

(2) A veteran described in this paragraph is a veteran who is a beneficiary of a health-plan contract under which recovery or collection is sought under this section from the third party concerned for the cost of the care or services furnished to the veteran.

(3) Records shall be made available under this subsection under such conditions to protect the confidentiality of such records as the Secretary shall prescribe in regulations.

(i) For purposes of this section —

(1)(A) The term "health-plan contract" means an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid.

(B) Such term does not include —

(i) an insurance program described in section

1811 of the Social Security Act (42 U.S.C. 1395c) or established by section 1831 of such Act (42 U.S.C. 1395j);

(ii) a State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1396 et seq.);

(iii) a workers' compensation law or plan described in subparagraph (A) of subsection (a)(2) of this section; or

(iv) a program, plan, or policy under a law described in subparagraph (B) or (C) of such subsection.

(2) The term "payment" includes reimbursement and indemnification.

(3) The term "third party" means —

(A) a State or political subdivision of a State;

(B) an employer or an employer's insurance carrier;

(C) an automobile accident reparations insurance carrier; or

(D) a person obligated to provide, or to pay the expenses of, health services under a health-plan contract.

(Added Pub. L. 97-72, title I, § 106(a)(1), Nov. 3, 1981, 95 Stat. 1050, § 629, and amended Pub. L. 99-272, Title XIX, § 19013(a), Apr. 7, 1986, 100 Stat. 382; Pub. L. 100-322, Title II, § 202, May

20, 1988, 102 Stat. 509; Pub. L. 101-508, Title VIII, § 8011(a)-(c), Nov. 5, 1990, 104 Stat. 1388 — 344; Pub. L. 102-40, Title IV, § 402(d)(1), May 7, 1991, 105 Stat. 239; renumbered and amended Pub. L. 102-83, §§ 4(b)(1), 5(a), (c)(1), Aug. 6, 1991, 105 Stat. 404, 406.)

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42 U.S.C. § 1395ss

§ 1395ss. Certification of medicare supplemental health insurance policies

(a) Submission of policy by insurer

(1) The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)(1) of this section) may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (c) of this section. Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards and requirements set forth in subsection (c) of this section. Subject to subsections (k)(3), (m), and (n) of this section, such certification shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and if the insurer submits such additional data as the Secretary find necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) such standards and requirements, he shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may prescribe) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received his certification.

(2) No medicare supplemental policy may be issued in a

State on or after the date specified in subsection (p)(1)(C) of this section, unless —

> (A) the State's regulatory program under subsection (b)(1) of this section provides for the application and enforcement of the standards and requirements set forth in such subsection (including the NAIC standards or the Federal standards (as the case may be)) by the date specified in subsection (p)(1)(C) of this section; or
>
> (B) if the State's program does not provide for the application and enforcement of such standards and requirements, the policy has been certified by the Secretary under paragraph (1) as meeting the standards and requirements set forth in subsection (c) of this section (including such applicable standards) by such date.

Any person who issues a medicare supplemental policy, after the effective date of the NAIC or Federal standards with respect to the policy, in violation of this paragraph is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1320a-7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(b) Supplemental Health Insurance Panel; required submission of advertising

(1) Any medicare supplemental policy issued in any State which the the[1] Secretary determines has established under State law a regulatory program that —

(A) provides for the application and enforcement of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A) of this section), except as otherwise provided by subparagraph H;

(B) includes requirements equal to or more stringent than the requirements described in paragraphs (2) through (5) of subsection (c) of this section;

(C) provides that —

(i) information with respect to the actual ratio of benefits provided to premiums collected under such policies will be reported to the State on forms conforming to those developed by the National Association of Insurance Commissioners for such purpose, or

(ii) such ratios will be monitored under the program in an alternative manner approved by the Secretary, and that a copy of each such policy, the most recent premium for each such policy, and a listing of the ratio of benefits provided to premiums collected for the most recent 3-year period for each such policy issued or sold in the State is maintained and made available to interested persons;

(D) provides for application and enforcement of the standards and requirements described in subparagraphs (A), (B), and (C) to all medicare supplemental policies (as defined in subsection (g)(1) of this section) issued in such State,

(E) provides the Secretary periodically (but at least annually) with a list containing the name and address of the issuer of each such policy and the name and number of each such policy (including an indication of policies that have been previously approved, newly approved, or withdrawn from approval since the previous list was provided),

(F) reports to the Secretary on the implementation and enforcement of standards and requirements of this paragraph at intervals established by the Secretary,

(G) provides for a process for approving or disapproving proposed premium increases with respect to such policies, and establishes a policy for the holding of public hearings prior to approval of a premium increase, and

(H) in the case of a policy that meets the standards under subparagraph (A) except that benefits under the policy are limited to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), provides for the application of requirements equal to or more stringent than the requirements under subsection (t) of this section,

shall be deemed (subject to subsections (k)(3), (m), and (n) of this section, for so long as the Secretary finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in subsection (c) of this section. The report required under subsection (F) shall include information on loss ratios of policies sold in the

State, frequency and types of instances in which policies approved by the State fail to meet the standards of this paragraph, actions taken by the State to bring such policies into compliance, and information regarding State programs implementing consumer protection provisions, and such further information as the Secretary in consultation with the National Association of Insurance Commissioners, may specify.

(2) The Secretary periodically shall review State regulatory programs to determine if they continue to meet the standards and requirements specified in paragraph (1). If the Secretary finds that a State regulatory program no longer meets the standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the State regulatory program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the program shall no longer be considered to have in operation a program meeting such standards and requirements.

(3) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c) of this section, with respect to an advertisement (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for review or approval to the extent it may be required under State law.

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(c) Requisite findings

The Secretary shall certify under this section any medicare supplemental policy, or continue certification of such a policy, only if he finds that such policy (or, with respect to paragraph (3), the issuer of the policy) —

(1) meets or exceeds (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another) the NAIC Model Standards (except as otherwise provided by subsection (t) of this section);

(2) meets the requirements of subsection (r) of this section;

(3)(A) accepts a notice under section 1395u(h)(3)(B) of this title as a claim form for benefits under such policy in lieu of any claim form otherwise required and agrees to make a payment determination on the basis of the information contained in such notice;

(B) where such a notice is received —

(i) provides notice to such physician or supplier and the beneficiary of the payment determination under the policy, and

(ii) provides any payment covered by such policy directly to the participating physician or supplier involved;

(C) provides each enrollee at the time of enrollment a card listing the policy name and number and a single mailing address to which notices under section 1395u(h)(3)(B) of this title respecting the policy are to be sent;

(D) agrees to pay any user fees established under section 1395u(h)(3)(B) of this title with respect to information transmitted to the issuer of the policy; and

(E) provides to the Secretary at least annually, for transmittal to carriers, a single mailing address to which notices under section 1395u(h)(3)(B) of this title respecting the policy are to be sent;

(4) may, during a period of not less than 30 days after the policy is issued, be returned for a full refund of any premiums paid (without regard to the manner in which the purchase of the policy was solicited); and

(5) meets the applicable requirements of subsections (*o*) through (t) of this section.

(d) Criminal penalties; civil penalties for certain violations

(1) Whoever knowingly and willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards and requirements set forth in subsection (c) of this section or in regulations promulgated pursuant to such subsection, or with respect to the use of the emblem designed by the Secretary under subsection (a) of this section, shall be fined under Title 18 or imprisoned not more than 5

years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty or not to exceed $5,000 for each such prohibited act.

(2) Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting, under the authority of or in association with, the program of health insurance established by this subchapter, or any Federal agency for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, shall be fined under Title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(3)(A) It is unlawful for a person to sell or issue a health insurance policy to an individual entitled to benefits under part A or enrolled under part B of this subchapter, with knowledge that such policy duplicates health benefits to which such individual is otherwise entitled, other than benefits to which he is entitled under a requirement of State or Federal law (other than this subchapter or subchapter XIX of this chapter). Whoever violates the previous sentence shall be fined under Title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a person other than the issuer of the policy) for each such prohibited act. A seller (who is not the issuer of a health insurance policy) shall not be considered to violate the previous sentence if the policy is sold in compliance with subparagraph (B) and the statement under such subparagraph indicates on its face that the sale of the policy will not duplicate health benefits to which the individual is otherwise entitled. This subsection shall not apply to such a seller until such date as the

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Secretary publishes a list of the standardized benefit packages that may be offered consistent with subsection (p) of this section.

(B)(i) It is unlawful for a person to issue or sell a medicare supplemental policy to an individual entitled to benefits under part A of this subchapter or enrolled under part B of this subchapter, whether directly, through the mail, or otherwise, unless —

> (I) the person obtains from the individual, as part of the application for the issuance or purchase and on a form described in clause (ii), a written statement signed by the individual stating, to the best of the individual's knowledge, what health insurance policies the individual has, from what source, and whether the individual is entitled to any medical assistance under subchapter XIX of this chapter, whether as a qualified medicare beneficiary or otherwise, and
>
> (II) the written statement is accompanied by a written acknowledgment, signed by the seller of the policy, of the request for and receipt of such statement.

(ii) The statement required by clause (i) shall be made on a form that —

> (I) states in substance that a medicare-eligible individual does not need more than one medicare supplemental policy,
>
> (II) states in substance that individuals 65 years of age or older may be eligible for benefits under the State medicaid program under subchapter XIX of this chapter and that such individuals who are entitled to benefits

under that program usually do not need a medicare supplemental policy that benefits and premiums under any such policy shall be suspended upon request of the policy holder during the period (of not longer than 24 months) of entitlement to benefits under such subchapter and may be reinstituted upon loss of such entitlement, and

(III) states that counseling services may be available in the State to provide advice concerning the purchase of medicare supplemental policies and enrollment under the medicaid program and may provide the telephone number for such services.

(iii)(I) Except as provided in subclauses (II) and (III), if the statement required by clause (i) is not obtained or indicates that the individual has another medicare supplemental policy or indicates that the individual is entitled to any medical assistance under subchapter XIX of this chapter, the sale of such a policy shall be considered to be a violation of subparagraph (A).

(II) Subclause (I) shall not apply in the case of an individual who has another policy, if the individual indicates in writing, as part of the application for purchase, that the policy being purchased replaces such other policy and indicates an intent to terminate the policy being replaced when the new policy becomes effective and the issuer or seller certifies in writing that such policy will not, to the best of the issuer or seller's knowledge, duplicate coverage (taking into account any such replacement).

(III) Subclause (I) also shall not apply if a State medicaid plan under subchapter XIX of this chapter pays the premiums for the policy, or pays less than an individual's (who is described in

section 1396d(p)(1) of this title) full liability for medicare cost sharing as defined in section 1396d(p)(3)(A) of this title.

(iv) Whoever issues or sells a medicare supplemental policy in violation of this subparagraph shall be fined under Title 18, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not the issuer of a policy) for each such violation.

(C) Subparagraph (A) shall not apply with respect to the selling of a group policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations.

(4)(A) Whoever knowingly, directly or through his agent, mails or causes to be mailed any matter for a prohibited purpose (as determined under subparagraph (B)) shall be fined under Title 18 or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

(B) For purposes of subparagraph (A), a prohibited purpose means the advertising, solicitation, or offer for sale of a medicare supplemental policy, or the delivery of such a policy, in or into any State in which such policy has not been approved by the State commissioner or superintendent of insurance.

(C) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a medicare supplemental policy

into a State if such person has ascertained that the party insured under such policy to whom (or on whose behalf) such policy is mailed is located in such State on a temporary basis.

(D) Subparagraph (A) shall not apply in the case of a person who mails or causes to be mailed a duplicate copy of a medicare supplemental policy previously issued to the party to whom (or on whose behalf) such duplicate copy is mailed, if such policy expires not more than 12 months after the date on which the duplicate copy is mailed.

(5) The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to civil money penalties under paragraphs (1), (2), (3)(A), and (4)(A) in the same manner as such provisions apply to penalties and proceedings under section 1320a-7a(a) of this title.

(e) Dissemination of Information

(1) The Secretary shall provide to all individuals entitled to benefits under this subchapter (and, to the extent feasible, to individuals about to become so entitled) such information as will permit such individuals to evaluate the value of medicare supplemental policies to them and the relationship of any such policies to benefits provided under this subchapter.

(2) The Secretary shall —

(A) inform all individuals entitled to benefits under this subchapter (and, to the extent feasible, individuals about to become so entitled) of —

(i) the actions and practices that are subject to sanctions under subsection (d) of this section, and

(ii) the manner in which they may report any such action or practice to an appropriate official of the Department of Health and Human Services (or to an appropriate State official), and

(B) publish the toll-free telephone number for individuals to report suspected violations of the provisions of such subsection.

(3) The Secretary shall provide individuals entitled to benefits under this subchapter (and, to the extent feasible, individuals about to become so entitled) with a listing of the addresses and telephone numbers of State and Federal agencies and offices that provide information and assistance to individuals with respect to the selection of medicare supplemental policies.

(f) Study and evaluation of comparative effectiveness of various State approaches to regulating medicare supplemental policies; report to Congress no later than January 1, 1982; periodic evaluations

(1)(A) The Secretary shall, in consultation with Federal and State regulatory agencies, the National Association of Insurance Commissioners, private insurers, and organizations representing consumers and the aged, conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of medicare supplemental policies in (i) limiting marketing and agent abuse, (ii) assuring the dissemination of such information to individuals entitled to benefits under this subchapter (and to other consumers) as is necessary to permit informed choice, (iii) promoting policies which provide reasonable economic benefits for such individuals, (iv) reducing the purchase of unnecessary duplicative coverage,

(v) improving price competition, and (vi) establishing effective approved State regulatory programs described in subsection (b) of this section.

(B) Such study shall also address the need for standards or certification of health insurance policies, other than medicare supplemental policies, sold to individuals eligible for benefits under this subchapter.

(C) The Secretary shall, no later than January 1, 1982, submit a report to the Congress on the results of such study and evaluation, accompanied by such recommendations as the Secretary finds warranted by such results with respect to the need for legislative or administrative changes to accomplish the objectives set forth in subparagraphs (A) and (B), including the need for a mandatory Federal regulatory program to assure the marketing of appropriate types of medicare supplemental policies, and such other means as he finds may be appropriate to enhance effective State regulation of such policies.

(2) The Secretary shall submit to the Congress no later than July 1, 1982, and periodically as may be appropriate thereafter (but not less often than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section, and shall include in such reports an analysis of—

> (A) the impact of such procedure and penalties on the types, market share, value, and cost to individuals entitled to benefits under this subchapter of medicare supplemental policies which have been certified by the Secretary;

(B) the need for any change in the certification procedure to improve its administration or effectiveness; and

(C) whether the certification program and criminal penalties should be continued.

(g) Definitions

(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this subchapter, which provides reimbursement for expenses incurred for services and items for which payment may be made under this subchapter but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this subchapter; but does not include any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof), or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of a health maintenance organization or other direct service organization which offers benefits under this subchapter, including such services under a contract under under[1] section 1395mm of this title or an agreement under section 1395l of this title. For purposes of this section, the term "policy" includes a certificate issued under such policy.

(2) For purposes of this section:

(A) The term "NAIC Model Standards" means the

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"NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act", adopted by the National Association of Insurance Commissioners on June 6, 1979, as it applies to medicare supplement[2] policies.

(B) The term "State with an approved regulatory program" means a State for which the Panel has made a determination under subsection (b)(1) of this section.

(C) The State in which a policy is issued means —

(i) in the case of an individual policy, the State in which the policyholder resides; and

(ii) in the case of a group policy, the State in which the holder of the master policy resides.

(h) Rules and regulations

The Secretary shall prescribe such regulations as may be necessary for the effective, efficient, and equitable administration of the certification procedure established under this section. The Secretary shall first issue final regulations to implement the certification procedure established under subsection (a) of this section not later than March 1, 1991.

(i) Commencement of certification program

(1) No medicare supplemental policy shall be certified and no such policy may be issued bearing the emblem authorized by the Secretary under subsection (a) of this section until July 1, 1982. On and after such date policies certified by the Secretary may bear

such emblem, including policies which were issued prior to such date and were subsequently certified, and insurers may notify holders of such certified policies issued prior to such date using such emblem in the notification.

(2)(A) The Secretary shall not implement the certification program established under subsection (a) of this section with respect to policies issued in a State unless the Panel makes a finding that such State cannot be expected to have established, by July 1, 1982, an approved State regulatory program meeting the standards and requirements of subsection (b)(1) of this section. If the Panel makes such a finding, the Secretary shall implement such program under subsection (a) of this section with respect to medicare supplemental policies issued in such State, until such time as the Panel determines that such State has a program that meets the standards and requirements of subsection (b)(1) of this section.

(B) Any finding by the Panel under subparagraph (A) shall be transmitted in writing, not later than January 1, 1982, to the Committee on Finance of the Senate and to the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives and shall not become effective until 60 days after the date of its transmittal to the Committees of the Congress under this subparagraph. In counting such days, days on which either House is not in session because of an adjournment sine die or an adjournment of more than three days to a day certain are excluded in the computation.

(j) State regulation of policies issued in other States

Nothing in this section shall be construed so as to affect the right of any State to regulate medicare supplemental policies

which, under the provisions of this section, are considered to be issued in another State.

(k) Amended NAIC Model Regulation or Federal model standards applicable; effective date; medicare supplemental policy and State regulatory program meeting applicable standards

(1)(A) If, within the 90-day period beginning on July 1, 1988, the National Association of Insurance Commissioners (in this subsection referred to as the "Association") amends the NAIC Model Regulation adopted on June 6, 1979 (as it relates to medicare supplemental policies), with respect to matters such as minimum benefit standards, loss rations, disclosure requirements, and replacement requirements and provisions otherwise necessary to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, except as provided in subsection (m) of this section, subsection (g)(2)(A) of this section shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the Model Regulation as amended by the Association in accordance with this paragraph (in this subsection and subsection (*l*) of this section referred to as the "amended NAIC Model Regulation").

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the amended NAIC Model Regulation or 1 year after the date the Association first adopts such amended Regulation.

(2)(A) If the Association does not amend the NAIC Model Regulation within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end

of such period, Federal model standards (in this subsection and subsection (*l*) referred to as "Federal model standards") for medicare supplemental policies to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, and subsection (g)(2)(A) of this section shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to Federal model standards.

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the Federal model standards or 1 year after the date the Secretary first promulgates such standards.

(3) Notwithstanding any other provision of this section (except as provided in subsections (*l*), (m), and (n) of this section) —

> (A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a) of this section,
>
> (B) no certification made pursuant to subsection (a) of this section shall remain in effect, and
>
> (C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A) of this section,

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulations or the Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

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(*l*) Transitional compliance with NAIC Model Transition Regulation; "qualifying medicare supplemental policy" and "NAIC Model Transition Regulation" defined; report to Congress respecting State action in adopting equal or more stringent standards

(1) Until the date specified in paragraph (3), in the case of a qualifying medicare supplemental policy described in paragraph (2) issued —

(A) before January 1, 1989, the policy is deemed to remain in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation (including giving notices to subscribers and filing for premium adjustments with the State as described in section 5.B. of such Regulation) by January 1, 1989; or

(B) on or after January 1, 1989, the policy is deemed to be in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation before the date of the sale of the policy.

(2) In paragraph (1), the term "qualifying medicare supplemental policy" means a medicare supplemental policy —

(A) issued in a State which —

(i) has not adopted standards equal to or more stringent than the NAIC Model Transition Regulation by January 1, 1989, and

(ii) has not adopted standards equal to or more

stringent than the amended NAIC Model Regulation (or federal model standards) buy January 1, 1989; and

(B) which has been issued in compliance with this section (as in effect on June 1, 1988).

(3)(A) The date specified in this paragraph is the earlier of —

(i) the first date a State adopts, after January 1, 1989, standards equal to or more stringent than the NAIC Model Transition Regulation or equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), as the case may be, or

(ii) the later of (I) the date specified in subsection (k)(1)(B) or (k)(2)(B) of this section (as the case may be), or (II) the date specified in subparagraph (B).

(B) In the case of a State which the Secretary identified as —

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

(ii) having a legislature which is not scheduled to meet in 1989 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1989, and in which legislation described in clause (i) may be

considered. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(4) In the case of a medicare supplemental policy in effect on January 1, 1989, and offered in a State which, as of such date —

(A) has adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), but

(B) does not have in effect standards equal to or more stringent than the NAIC Model Transition Regulation (or otherwise requiring notice substantially the same as the notice required in section 5.B. of such Regulation),

the policy shall not be deemed to meet the standards in subsection (c) of this section unless each individual who is entitled to benefits under this subchapter and is a policyholder under such policy on January 1, 1989, is sent such a notice in any appropriate form by not later than January 31, 1989, that explains —

(A) the improved benefits under this subchapter contained in the Medicare Catastrophic Coverage Act of 1988, and

(B) how these improvements affect the benefits contained in the policies and the premium for the policy.

(5) In this subsection, the term "NAIC Model Transition Regulation" refers to the standards contained in the "Model Regulation to Implement Transitional Requirements for the

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Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions" (as adopted by the National Association of Insurance Commissioners in September 1987).

(6) The Secretary shall report to the Congress in March 1989 and in July 1990 on actions States have taken in adopting standards equal to or more stringent than the NAIC Model Transition Regulation or the amended NAIC Model Regulation (or Federal model standards).

(m) Revision of amended NAIC Model Regulation and amended Federal model standards; effective dates; medicare supplemental policy and State regulatory program meeting applicable standards

(1)(A) If, within the 90-day period beginning on December 13, 1989, the National Association of Insurance Commissioners (in this subsection and subsection (n) of this section referred to as the "Association") revises the amended NAIC Model Regulation (referred to in subsection (k)(1)(A) of this section and adopted on September 20, 1988) to improve such regulation and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) of this section shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the amended NAIC Model Regulation (referred to in subsection (k)(l)(A) of this section) as revised by the Association in accordance with this paragraph (in this subsection and subsection (n) of this section referred to as the "revised NAIC Model Regulation").

(B) The date specified in this subparagraph for a State is the

earlier of the date the State adopts standards equal to or more stringent than the revised NAIC Model Regulation or 1 year after the date the Association first adopts such revised Regulation.

(2)(A) If the Association does not revise the amended NAIC Model Regulation, within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, revised Federal model standards (in this subsection and subsection (n) of this section referred to as "revised Federal model standards") for medicare supplemental policies to improve such standards and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) of this section shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised Federal model standards.

(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised Federal model standards or 1 year after the date the Secretary first promulgates such standards.

(3) Notwithstanding any other provision of this section (except as provided in subsection (n) of this section) —

(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a) of this section,

(B) no certification made pursuant to subsection (a) of this section shall remain in effect, and

(C) no State regulatory program shall be found to

meet (or to continue to meet) the requirements of subsection (b)(1)(A) of this section,

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

(n) Transition compliance with revision of NAIC Model Regulation and Federal model standards

(1) Until the date specified in paragraph (4), in the case of a qualifying medicare supplemental policy described in paragraph (3) issued in a State —

(A) before the transition deadline, the policy is deemed to remain in compliance with the standards described in subsection (b)(1)(A) of this section only if the insurer issuing the policy complies with the transition provision described in paragraph (2), or

(B) on or after the transition deadline, the policy is deemed to be in compliance with the standards described in subsection (b)(1)(A) of this section only if the insurer issuing the policy complies with the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) before the date of the sale of the policy.

In this paragraph, the term "transition deadline" means 1 year after the date the Association adopts the revised NAIC Model Regulation or 1 year after the date the Secretary promulgates revised Federal model standards (as the case may be).

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(2) The transition provision described in this paragraph is —

(A) such transition provision as the Association provides, by not later than December 15, 1989, so as to provide for an appropriate transition (i) to restore benefit provisions which are no longer duplicative as a result of the changes in benefits under this subchapter made by the Medicare Catastrophic Coverage Repeal Act of 1989 and (ii) to eliminate the requirement of payment for the first 8 days of coinsurance for extended care services, or

(B) if the Association does not provide for a transition provision by the date described in subparagraph (A), such transition provision as the Secretary shall provide, by January 1, 1990, so as to provide for an appropriate transition described in subparagraph (A).

(3) In paragraph (1), the term "qualifying medicare supplemental policy" means a medicare supplemental policy which has been issued in compliance with this section as in effect on the date before December 13, 1989.

(4)(A) The date specified in this paragraph for a policy issued in a State is —

(i) the first date a State adopts, after December 13, 1989, standards equal to or more stringent than the revised NAIC Model Regulation (or revised Federal model standards), as the case may be, or

(ii) the date specified in subparagraph (B),

whichever is earlier.

(B) In the case of a State which the Secretary identifies, in consultation with the Association, as —

> (i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but
>
> (ii) having a legislature which is not scheduled to meet in 1990 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1990. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(5) In the case of a medicare supplemental policy in effect on January 1, 1990, the policy shall not be deemed to meet the standards in subsection (c) of this section unless each individual who is entitled to benefits under this subchapter and is a policyholder or certificate holder under such policy on such date is sent a notice in an appropriate form by not later than January 31, 1990, that explains —

> (A) the changes in benefits under this subchapter effected by the Medicare Catastrophic Coverage Repeal Act of 1989, and
>
> (B) how these changes may affect the benefits contained in such policy and the premium for the policy.

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(6)(A) Except as provided in subparagraph (B), in the case of an individual who had in effect, as of December 31, 1988, a medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificate holder) and the individual terminated coverage under such policy before December 13, 1989, no medicare supplemental policy of the insurer shall be deemed to meet the standards in subsection (c) of this section unless the insurer —

(i) provides written notice, no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificate holder (at the most recent available address) of the offer described in clause (ii), and

(ii) offers the individual, during a period of at least 60 days beginning not later than February 1, 1990, reinstitution of coverage (with coverage effective as of January 1, 1990), under the terms which (I) do not provide for any waiting period with respect to treatment of pre-existing conditions, (II) provides for coverage which is substantially equivalent to coverage in effect before the date of such termination, and (III) provides for classification of premiums on which terms are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage never terminated.

(B) An insurer is not required to make the offer under subparagraph (A)(ii) in the case of an individual who is a policyholder or certificate holder in another medicare supplemental policy as of December 13, 1989, if (as of January 1,

1990) the individual is not subject to a waiting period with respect to treatment of a pre-existing condition under such other policy.

(*o*) Requirements of group benefits; core group benefits; uniform outline of coverage

The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall provide for coverage of a group of benefits consistent with subsection (p) of this section.

(2) If the medicare supplemental policy provides for coverage of a group of benefits other than the core group of basic benefits described in subsection (p)(2)(B) of this section, the issuer of the policy must make available to the individual a medicare supplemental policy with only such core group of basic benefits.

(3) The issuer of the policy has provided, before the sale of the policy, an outline of coverage that uses uniform language and format (including layout and print size) that facilitates comparison among medicare supplemental policies and comparison with medicare benefits.

(p) Standards for group benefits

(1)(A) If, within 9 months after November 5, 1990, the National Association of Insurance Commissioners (in this subsection referred to as the "Association") promulgates —

(i) limitations on the groups or packages of

benefits that may be offered under a medicare supplemental policy consistent with paragraphs (2) and (3) of this subsection,

(ii) uniform language and definitions to be used with respect to such benefits,

(iii) uniform format to be used in the policy with respect to such benefits, and

(iv) other standards to meet the additional requirements imposed by the amendments made by the Omnibus Budget Reconciliation Act of 1990,

(such limitations, language, definitions, format, and standards referred to collectively in this subsection as "NAIC standards"), subsection (g)(2)(A) of this section shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, included a reference to the NAIC standards.

(B) If the Association does not promulgate NAIC standards within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, limitations, language, definitions, format, and standards described in clauses (i) through (iv) of such subparagraph (in this subsection referred to collectively as "Federal standards") and subsection (g)(2)(A) of this section shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, included a reference to the Federal standards.

(C)(i) Subject to clause (ii), the date specified in this subparagraph for a State is the date the State adopts the NAIC standards or the Federal standards or 1 year after the date the Association or the Secretary first adopts such standards, whichever is earlier.

(ii) In the case of a State which the Secretary identifies, in consultation with the Association, as —

> (I) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the NAIC or Federal standards, but
>
> (II) having a legislature which is not scheduled to meet in 1992 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1992. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(D) In promulgating standards under this paragraph, the Association or Secretary shall consult with a working group composed of representatives of issuers of medicare supplemental policies, consumer groups, medicare beneficiaries, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.

(E) If benefits (including deductibles and coinsurance) under

this subchapter are changed and the Secretary determines, in consultation with the Association, that changes in the NAIC or Federal standards are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

(2) The benefits under the NAIC or Federal standards shall provide —

(A) for such groups or packages of benefits as may be appropriate taking into account the considerations specified in paragraph (3) and the requirements of the succeeding subparagraphs;

(B) for identification of a core group of basic benefits common to all policies, and

(C) that, subject to paragraph (5)(B), the total number of different benefit packages (counting the core group of basic benefits described in subparagraph (B) and each other combination of benefits that may be offered as a separate benefit package) that may be established in all the States and by all issuers shall not exceed 10.

(3) The benefits under paragraph (2) shall, to the extent possible —

(A) provide for benefits that offer consumers the ability to purchase the benefits that are available in the market as of November 5, 1990; and

(B) balance the objectives of (i) simplifying the market to facilitate comparisons among policies, (ii) avoiding adverse selection, (iii) providing consumer choice, (iv) providing market stability, and (v) promoting competition.

(4)(A)(i) Except as provided in subparagraph (B), no State with a regulatory program approved under subsection (b)(1) of this section may provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy unless such grouping meets the applicable standards.

(ii) Except as provided in subparagraph (B), the Secretary may not provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy seeking approval by the Secretary unless such grouping meets the applicable standards.

(B) With the approval of the State (in the case of a policy issued in a State with an approved regulatory program) or the Secretary (in the case of any other policy), the issuer of a medicare supplemental policy may offer new or innovative benefits in addition to the benefits provided in a policy that otherwise complies with the applicable standards. Any such new or innovative benefits may include benefits that are not otherwise available and are cost-effective and shall be offered in a manner which is consistent with the goal of simplification of medicare supplemental policies.

(5)(A) Except as provided in subparagraph (B), this subsection shall not be construed as preventing a State from restricting the groups of benefits that may be offered in medicare supplemental policies in the State.

(B) A State with a regulatory program approved under subsection (b)(1) of this section may not restrict under subparagraph (A) the offering of a medicare supplemental policy consisting only of the core group of benefits described in paragraph (2)(B).

(6) The Secretary may waive the application of standards in regard to the limitation of benefits described in paragraph (4) in those States that on November 5, 1990, had in place an alternative simplification program.

(7) This subsection shall not be construed as preventing an issuer of a medicare supplemental policy who otherwise meets the requirements of this section from providing, through an arrangement with a vendor, for discounts from that vendor to policyholder or certificateholders for the purchase of items or services not covered under its medicare supplemental policies.

(8) Any person who sells or issues a medicare supplemental policy, after the effective date of the NAIC or Federal standards with respect to the policy, in violation of the previous requirements of this subsection is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not an issuer of a policy) for each such violation. The provisions of section 1320a-7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(9)(A) Anyone who sells a medicare supplemental policy to an individual shall make available for sale to the individual a medicare supplemental policy with only the core group of basic benefits (described in paragraph (2)(B)).

(B) Anyone who sells a medicare supplemental policy to an individual shall provide the individual, before the sale of the policy, an outline of coverage which describes the benefits under the policy. Such outline shall be on a standard form approved by the State regulatory program or the Secretary (as the case may be) consistent with the NAIC or Federal standards under this subsection.

(C) Whoever sells a medicare supplemental policy in violation of this paragraph is subject to a civil money penalty of not to exceed $25.000 (or $15,000 in the case of a seller who is not the issuer of the policy) for each such violation. The provisions of section 1320a-7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(10) No penalty may be imposed under paragraph (8) or (9) in the care[3] of a seller who is not the issuer of a policy until the Secretary has published a list of the groups of benefit packages that may be sold or issued consistent with this subsection.

(q) Guaranteed renewal of policies; termination; suspension

The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall be guaranteed renewable and —

(A) the issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(B) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(2) If the medicare supplemental policy is terminated by the group policyholder and is not replaced as provided under paragraph (2), the issuer shall offer certificateholders an individual medicare supplemental policy which (at the option of the certificateholder) —

(A) provides for continuation of the benefits contained in the group policy, or

(B) provides for such benefits as otherwise meets the requirements of this section.

(3) If an individual is a certificateholder in a group medicare supplemental policy and the individual terminates membership in the group, the issuer shall —

(A) offer the certificateholder the conversion opportunity described in paragraph (2), or

(B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(4) If a group medicare supplemental policy is replaced by another group medicare supplemental policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result

in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(5)(A) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period (not to exceed 24 months) in which the policyholder has applied for and is determined to be entitled to medical assistance under subchapter XIX of this chapter, but only if the policyholder notifies the issuer of such policy within 90 days after the date the individual becomes entitled to such assistance. If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy shall be automatically reinstituted (effective as of the date of termination of such entitlement) under terms described in subsection (n)(6)(A)(ii) of this section as of the termination of such entitlement if the policyholder provides notice of loss of such entitlement within 90 days after the date of such loss.

(B) Nothing in this section shall be construed as affecting the authority of a State, under subchapter XIX of this chapter, to purchase a medicare supplemental policy for an individual otherwise entitled to assistance under such subchapter.

(C) Any person who issues a medicare supplemental policy and fails to comply with the requirements of this paragraph is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1320a-7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

Appendix D

(r) Loss ratios and minimum refund of premiums and/or return of benefits and/or credits to policyholders; loss ratio compliance audits

(1) A medicare supplemental policy may not be issued or sold in any State unless

> (A) the policy can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such periods and in accordance with a uniform methodology, including uniform reporting standards, developed by the National Association of Insurance Commissioners,[4] to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 65 percent in the case of individual policies; and
>
> (B) the issuer of the policy provides for the issuance of a proportional refund, or a credit against future premiums of a proportional amount, based on the premium paid and in accordance with paragraph (2), of the amount of premiums received necessary to assure that the ratio of aggregate benefits provided to the aggregate premiums collected (net of such refunds or credits) complies with the expectation required under subparagraph (A).

For purposes of applying subparagraph (A) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

Appendix D

(2)(A) Paragraph (l)(B) shall be applied with respect to each type of policy by policy number. Paragraph (1)(B) shall not apply to a policy with respect to the first 2 years in which it is in effect. The Comptroller General, in consultation with the National Association of Insurance Commissioners, shall submit to Congress a report containing recommendations on adjustments in the percentages under paragraph (l)(A) that may be appropriate in order to apply paragraph (l)(B) to the first 2 years in which policies are effective.

(B) A refund or credit required under paragraph (l)(B) shall be made to each policyholder insured under the applicable policy as of the last day of the year involved.

(C) Such a refund or credit shall include interest from the end of the policy year involved until the date of the refund or credit at a rate as specified by the Secretary for this purpose from time to time which is not less than the average rate of interest for 13-week Treasury notes.

(D) For purposes of this paragraph and paragraph (l)(B), refunds or credits against premiums due shall be made, with respect to a policy year, not later than the third quarter of the succeeding policy year.

(3) The provisions of this subsection do not preempt a State from requiring a higher percentage than that specified in paragraph (l)(A).

(4) The Secretary shall submit in February of each year (beginning with 1993) a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on loss-ratios under

medicare supplemental policies and the use of sanctions, such as a required rebate or credit or the disllowance[5] of premium increases, for policies that fail to meet the requirements of this subsection (relating to loss-ratios). Such report shall include a list of the policies that failed to comply with such loss-ratio requirements or other requirements of this section.

(5)(A) The Comptroller General shall periodically, not less often than once every 3 years, perform audits with respect to the compliance of medicare supplemental policies with the loss ratio requirements of this subsection and shall report the results of such audits to the State involved and to the Secretary.

(B) The Secretary may independently perform such compliance audits.

(6)(A) A person who issues a policy in violation of the loss ratio requirements of this subsection is subject to a civil money penalty of not to exceed $25,000 for each such violation. The provisions of section 1320a-7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) Each issuer of a policy subject to the requirements of paragraph (l)(B) shall be liable to policyholders for credits required under such paragraph.

(t)[6] Medicare select policies

(1) If a policy meets the NAIC Model Standards and otherwise complies with the requirements of this section except

that benefits under the policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), the policy shall nevertheless be treated as meeting those standards if —

(A) full benefits are provided for items and services furnished through a network of entities which have entered into contracts with the issuer of the policy;

(B) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network;

(C) the network offers sufficient access;

(D) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network;

(E)(i) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of (I) the restrictions on payment under the policy for services furnished other than by or through the network, (II) out of area coverage under the policy, (III) the policy's coverage of emergency services and urgently needed care, and (IV) the availability of a policy through the entity that meets the NAIC standards without reference to this subsection and the premium charged for such policy, and

(ii) each enrollee prior to enrollment acknowledges receipt of the explanation provided under clause (i); and

(F) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the NAIC standards and other requirements of this section without reference to this subsection.

(2) If the Secretary determines that an issuer of a policy approved under paragraph (1) —

(A) fails substantially to provide medically necessary items and services to enrollees seeking such items and services through the issuer's network, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual,

(B) imposes premiums on enrollees in excess of the premiums approved by the State,

(C) acts to expel an enrollee for reasons other than nonpayment of premiums, or

(D) does not provide the explanation required under paragraph (1)(E)(i) or does not obtain the acknowledgment required under paragraph (1)(E)(ii),

is subject to a civil money penalty in an amount not to exceed $25,000 for each such violation. The provisions of section 1320a-7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty

under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(3) The Secretary may enter into a contract with an entity whose policy has been certified under paragraph (1) or has been approved by a State under subsection (b)(l)(H) to determine whether items and services (furnished to individuals entitled to benefits under this subchapter and under that policy) are not allowable under section 1395y(a)(1) of this title. Payments to the entity shall be in such amounts as the Secretary may determine, taking into account estimated savings under contracts with carriers and fiscal intermediaries and other factors that the Secretary finds appropriate. Paragraph (1), the first sentence of paragraph (2)(A), paragraph (2)(B), paragraph (3)(C), paragraph (3)(D), and paragraph (3)(E) of section 1395u(b) of this title shall apply to the entity.

(Aug. 14, 1935, c. 531, Title § XVIII, § 1882, as added June 9, 1980, Pub.L. 96-265, Title V, § 507(a), 94 Stat. 476, and amended H.Res. 549, Mar. 25, 1980; Aug. 18, 1987, Pub.L. 100-93, § 13, 101 Stat. 697; Dec. 22, 1987, Pub.L. 100-203, Title IV, § 4081(b), 101 Stat. 1330-127; July 1, 1988, Pub.L. 100-360, Title II, § 221(a)-(f), Title IV, §§ 411(i)(1)(B), (C), 428(b), 102 Stat. 742-746, 788, 817; Dec. 13, 1989, Pub.L. 101-234, Title II, § 203(a), 103 Stat. 1982, Nov. 5, 1990, Pub.L. 101-508, Title IV, §§ 4207(k)(1), 4351(a), 4352, 4353(a)(d)(1), 4354(a), (b), 4355(a)-(c), 4356(a), 4357(a), 4358(a), (b), 104 Stat. 1388-124, 1388-125, 1388-129, 1388-130, 1388-132, 1388-134, 1388-135, 1388-136, 1388-137.)

Appendix D

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1. So in original.

2. So in original. Probably should be "supplemental".

3. So in original. Probably should be "case".

4. So in original. Probably should be "Commissioners),".

5. So in original. Probably should be "disallowance".

6. So in original. For text of subsec. (s), see italicized note set out under this section.

Supreme Court, U.S.
FILED
FEB 2 1994
CLERK

No. 93-865

In the Supreme Court of the United States

OCTOBER TERM, 1993

BLUE CROSS AND BLUE SHIELD OF ALABAMA,
PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTION PRESENTED

Whether, under petitioner's Medicare supplemental health insurance (medigap) policies, petitioner may deny reimbursement to a Veterans Affairs hospital for medical services that are provided to Medicare-eligible patients, but for which the Medicare program does not provide reimbursement.

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In the Supreme Court of the United States

OCTOBER TERM, 1993

No. 93-865

BLUE CROSS AND BLUE SHIELD OF ALABAMA,
PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-10a) is reported at 999 F.2d 1542. The opinion of the district court (Pet. App. 11a-16a) is reported at 791 F. Supp. 288.

JURISDICTION

The judgment of the court of appeals was entered on September 8, 1993, and a petition for rehearing was denied on October 15, 1993. Pet. App. 17a. The petition for a writ of certiorari was filed on December 1, 1993. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. This case is the latest of a number of cases to reach the appellate courts in which a private health insurance carrier has refused to honor a request by the Department of Veterans Affairs (VA) for reimbursement of the costs of medical services that VA provided free of charge to Medicare-eligible veterans.[1] Under the Veterans' Benefits Act of 1957, 38 U.S.C. 1701 *et seq.*, a veteran may be furnished hospital care for a non-service-connected disability if the veteran is unable to defray the cost of such care. 38 U.S.C. 1710(a)(1)(I) (Supp. IV 1992). In 1981, Congress determined that VA, as a provider of medical services, should be entitled to recover the reasonable costs of caring for a veteran's non-service-connected disability in those situations in which the veteran would be eligible to receive compensation for such medical care from a third party if the care had not been provided by VA. Veterans' Health Care, Training, and Small Business Loan Act of 1981, Pub. L. No. 97-72, Tit. I, § 106, 95 Stat. 1050-1051 (codified as amended at 38 U.S.C. 1729 (Supp. IV 1992)). Section 1729 [2] was specifically amended in 1986 to give the

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[1] This Court recently denied certiorari in *United States* v. *Blue Cross & Blue Shield of Maryland, Inc.*, 989 F.2d 718 (4th Cir.), cert. denied, 114 S. Ct. 302 (1993), where the Fourth Circuit held that a private insurer may not refuse to reimburse VA for costs that would otherwise be paid to a private hospital under the terms of the insurer's medigap policies. See also *United States* v. *Capital Blue Cross*, 992 F.2d 1270 (3d Cir. 1993) (same).

[2] The anti-discrimination provision was originally codified as 38 U.S.C. 629, but was amended and renumbered in 1991.

United States authority to pursue recovery from a veteran's medical insurer. Consolidated Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-272, Tit. XIX, § 19013, 100 Stat. 382-385. Because its purpose is to put VA on an equal footing with all other providers of medical services, and thus to prohibit insurers from denying reimbursement to VA when reimbursement would otherwise be paid to private hospitals, Section 1729 has generally been referred to as the "anti-discrimination" statute.[3] Further, Section 1729 prevents the abrogation of the statute by state law or private contract by providing that no state law and "no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section." 38 U.S.C. 1729(f) (Supp. IV 1992).

The statute defines the third parties from which the United States may recover the costs of medical services to include States, employers, automobile insurance carriers, and persons "obligated to provide,

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See Department of Veterans Affairs Codification Act, Pub. L. No. 102-83, § 5(a), 105 Stat. 406 (1991).

[3] 38 U.S.C. 1729(a)(1) (Supp. IV 1992) provides:

> Subject to the provisions of this section, in any case in which a veteran is furnished care or services under this chapter for a non-service-connected disability described in paragraph (2) of this subsection, the United States has the right to recover or collect the reasonable cost of such care or services (as determined by the Secretary) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.

or to pay the expenses of, health services under a health-plan contract." 38 U.S.C. 1729(i)(3)(D) (Supp. IV 1992). The term "health-plan contract" means "an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement, under which health services for individuals are provided or the expenses of such services are paid." 38 U.S.C. 1729(i)(1)(A) (Supp. IV 1992). The United States may enforce its right to recover through intervention, subrogation, or a separate action against the third-party payer. 38 U.S.C. 1729(b) (Supp. IV 1992).

b. Medicare Part A is a program of medical insurance providing insurance coverage for hospital care and related hospital services for persons who are over 65 years of age and who are eligible for Social Security retirement benefits. 42 U.S.C. 1395c. The Medicare Act and its implementing regulations set forth the conditions and limitations on the coverage of listed services and items, and they specify limits on what may be considered the reimbursable reasonable charge for covered services and items. See 42 C.F.R. Pts. 409-410. There are certain circumstances under which Medicare will not pay claims even though a patient qualifies for benefits and the services the patient receives are covered under the Act and regulations. As is relevant in this case, Medicare reimbursement is denied: (1) when the health care provider is a federal department or agency, 42 U.S.C. 1395f(c), 1395n(d); and (2) when the patient is not obligated to pay for the services provided, 42 U.S.C. 1395y(a)(2). Congress also specifically excluded Medicare from the definition of "health-plan contract" under 38 U.S.C. 1729(i)(1)(B)(i) (Supp. IV 1992), there-

by preventing VA from billing Medicare for the medical services it provides to Medicare-eligible patients. Those exclusions prevent VA hospitals from receiving Medicare reimbursement for medical services provided to veterans for non-service-connected disabilities for which the veterans are not obligated to pay.

Medicare also does not fully cover certain health care services. Thus, a patient remains responsible for paying various deductibles and coinsurance amounts. See 42 U.S.C. 1395e(a)(3). Private insurers fill these gaps in coverage by offering Medicare supplemental or "medigap" policies. Congress amended the Social Security Act in 1980 specifically to define medigap policies. See Social Security Disability Amendments of 1980, Pub. L. No. 96-265, § 507, 94 Stat. 476 (the Baucus Amendment) (codified as amended at 42 U.S.C. 1395ss). Section 1395ss defines a medigap policy to include (42 U.S.C. 1395ss(g)(1)):

> a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this subchapter, which provides reimbursement for expenses incurred for services and items for which payment may be made under this subchapter but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this subchapter * * *.

2. Petitioner Blue Cross and Blue Shield of Alabama (BCBS) is a private health insurance carrier that issues medigap policies in Alabama. The United States submitted claims to petitioner for reimburse-

ment on behalf of eight veterans[4] who held medigap policies (also referred to by BCBS as "C Plus" policies) issued by petitioner, and who had received medical care at VA hospitals in Alabama. Petitioner denied the claims on the ground that its medigap policies covered only those medical expenses incurred in a manner that would also trigger Medicare reimbursement. Because VA was not entitled to receive Medicare payments, the insurer denied the government's claims. The United States then instituted this action to recover benefits under the veterans' BCBS medigap policies, arguing that the anti-discrimination provision of the Veterans' Benefits Act (38 U.S.C. 1729) prohibited petitioner from refusing to pay.

The district court granted summary judgment in favor of the United States. Pet. App. 11a-16a. The court rejected petitioner's argument that it was not obligated by the terms of its medigap policies to pay any portion of the claims submitted by VA because the care and services were rendered by a "non-participating hospital." *Id.* at 12a. The court stated that while VA hospitals do not participate in Medicare,[5] "it is obvious that the Blue Cross Medigap

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[4] The United States originally sought to recover for the cost of medical care provided to nine veterans. Upon learning that one of the veterans was covered under a medigap policy issued by a BCBS of another State, the United States amended its complaint to delete reference to that veteran. See Pet. App. 3a n.3.

[5] The court opined that the obvious reason for the Act's exclusion of Medicare from the definition of "health plan contract," 38 U.S.C. 1729(i)(1)(A) was because "Congress decided not to 'rob Peter to pay Paul.'" Pet. App. 14a.

policy is a health plan contract." *Id.* at 14a. The court pointed out that if the veterans had been provided care and services in a participating private general hospital, they would have been eligible to receive payment from petitioner for deductibles and coinsurance. *Ibid.* Thus, the court concluded, the United States is entitled to recover under 38 U.S.C. 1729(a)(1). That result, the court declared, "flows ineluctably from the anti-discrimination provisions of 38 U.S.C. § 1729(f)." Pet. App. 14a. Accordingly, the court entered a declaratory judgment that Section 1729 applies to Medigap policies, and that petitioner is required to reimburse VA "for a portion of the cost of medical care and services received by veterans with non-service-connected disabilities at VA medical facilities who hold Medigap contracts with BCBS." Pet. App. 16a.

3. The court of appeals affirmed. Pet. App. 1a-10a. It first rejected petitioner's contention that 38 U.S.C. 1729 does not apply to medigap policies because they are not "health-plan contracts" within the meaning of the statute. Adopting instead the Fourth Circuit's reasoning in *United States* v. *Blue Cross & Blue Shield of Maryland, Inc.*, 989 F.2d 718, 727, cert. denied, 114 S. Ct. 302 (1993), the court below observed that "[a] health-plan contract need do only one of two things—provide health services or reimburse the expenses of such services." Pet. App. 6a. Here, the court concluded, petitioner's medigap policies "undoubtedly qualify as policies 'under which . . . the expenses of [health] services are paid.' 38 U.S.C. § 1729(i)(1)(A)." Pet. App. 6a. The court relied on both the language and the legislative history of Section 1729 in support of its conclusion that the "medigap

policies issued by Blue Cross are health-plan contracts governed by the reimbursement and anti-discrimination provisions of § 1729." Pet. App. 7a (citing *United States* v. *Capital Blue Cross*, 992 F.2d 1270 (3d Cir. 1993)).

The court of appeals also found no merit in petitioner's argument that the United States is prevented from seeking reimbursement because a condition precedent to recovery under the medigap policy—payment by Medicare—is statutorily precluded from occurring when the medical care is delivered by a VA hospital. Pet. App. 7a-9a. In this regard, the court noted that although the medigap policies do not explicitly discriminate against the United States, a "contractual provision that operates to prevent recovery by the United States * * * is prohibited by the statute even where the discrimination is not apparent from the face of the policy." *Id.* at 7a. In the court of appeals' view, petitioner's participating hospital provision in its medigap policies "clearly operates 'to prevent recovery or collection by the United States' in contravention of 38 U.S.C. §1729(f)." *Id.* at 8a. The court explained that "[i]n virtually all cases, because VA hospitals may not recover expenses from Medicare, 38 U.S.C. § 1729(i)(1)(A), the policies would prevent reimbursement to the United States." *Id.* at 7a-8a. On the other hand, Alabama's private general hospitals all participate in Medicare "and therefore virtually always qualify for recovery under the medigap policies." *Id.* at 8a. As a practical matter, then, "VA is denied recovery while private hospitals are not." *Ibid.* The court held that "[t]his result constitutes discrimination against the

United States in violation of 38 U.S.C. § 1729(f)." Pet. App. 9a.

Finally, the court rejected petitioner's argument that recovery by the United States would impair its Fifth Amendment right to contract. The court explained that "[t]he right to contract is not without bound," and that the "application of a regulatory statute that is otherwise valid may not be defeated by private contracts." Pet. App. 9a (citing *Connolly* v. *Pension Benefit Guaranty Corp.*, 475 U.S. 211, 224 (1986)). The court noted that petitioner did not challenge Congress's power to enact the anti-discrimination provisions of Section 1729, and it concluded that petitioner "cannot enter into contracts which violate existing law, then claim that the enforcement of that law infringes upon its right to contract." Pet. App. 9a.

Accordingly, the court of appeals held that petitioner "must determine eligibility for medigap coverage as though the veterans had received care from a private billing hospital which participated in and received reimbursement through the Medicare program." Pet. App. 9a-10a.

ARGUMENT

The decision of the court of appeals is correct and does not conflict with any decision of this Court or any other court of appeals. Indeed, as the Eleventh Circuit observed, "[t]his decision brings Blue Cross/Blue Shield of Alabama in line with * * * the plans in 19 states and the District of Columbia [which] all provide for reimbursement to the United States under medigap policies. * * * The plans have consistently lost in litigation involving the claims of

the United States." Pet. App. 10a (citing *United States* v. *Capital Blue Cross*, 992 F.2d 1270 (3d Cir. 1993); *United States* v. *Blue Cross & Blue Shield of Maryland, Inc.*, 989 F.2d 718 (4th Cir.), cert. denied, 114 S. Ct. 302 (1993)). Moreover, this Court recently declined to review the decision in *Blue Cross & Blue Shield of Maryland*, in which the Fourth Circuit rejected virtually the same arguments asserted by petitioner in this case. Review by this Court is therefore unwarranted.

At this stage, petitioner's sole contention (Pet. 5) is that, by holding that medigap policies are subject to the anti-discrimination provisions of 38 U.S.C. 1729, the court of appeals' decision imposes extra-contractual burdens on petitioner in violation of its Fifth Amendment right to contract.[6]

1. Petitioner first argues (Pet. 7) that because the "obligation to pay Medicare-derived costs is the

[6] Petitioner states (Pet. 6 n.1) that it "continues to contend before this Court that the C Plus policies are not 'health plan contracts' within the scope of 38 U.S.C. § 1729," but "for the sake of argument within this Petition, and without waiver of its remaining arguments before the lower courts," its arguments will focus "on the failure of Section 1729 to trigger liability under these policies even if they are considered to be included in the statutorily-defined third party payors." Rule 14.1(a) of the Rules of this Court provides, however, that "[o]nly the questions set forth in the petition, or fairly included therein, will be considered by the Court." The only question stated in the petition is: "Whether, in erroneously interpreting 38 U.S.C. § 1729, the courts below imposed extracontractual burdens upon Blue Cross by effectively changing the supplemental nature of the C Plus Medicare supplemental contracts in violation of Blue Cross's Fifth Amendment-protected right to contract?" Only that Fifth Amendment question is properly presented by the petition.

essence of the Medigap contract[,] * * * any requirement that Blue Cross pay for health services incurred outside the realm of the Medicare statutes in fact imposes a duty upon Blue Cross that was not contractually assumed when Blue Cross offered the C Plus contract." The Fourth Circuit in *Blue Cross & Blue Shield of Maryland* rejected a similar contention that "there is a federal statutory requirement that medigap policies operate necessarily and exclusively in tandem with Medicare payment," explaining that such an argument "confuses a person's entitlement to Medicare benefits with her actual ability to collect those benefits." 989 F.2d at 723. As the Fourth Circuit pointed out, the statutory provision precluding Medicare payments to VA hospitals is "a limitation to Medicare recovery but not to eligibility for the underlying benefits."[7] *Ibid.*

2. Petitioner next asserts (Pet. 10-12) that the medigap policies do not discriminate against the United States because the prerequisite of Medicare eligibility applies equally to private and public hospitals. Petitioner again confuses a patient's eligibility for Medicare reimbursement with the patient's actual ability to recover those benefits. Further, as the

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[7] The Fourth Circuit noted in *Blue Cross & Blue Shield of Maryland* that there are instances in which an individual might be eligible for Medicare, "yet still not receive reimbursement because she has not met a deductible, a coinsurance payment, or other limitation." 989 F.2d at 723. Further, there are instances in which a medigap policy will pay despite Medicare's failure to make reimbursement. *Id.* at 723-724 (citing examples). The court therefore concluded that payment under a medigap policy clearly "can be 'triggered' without payment of a Medicare benefit." *Id.* at 726.

court of appeals held, petitioner's participating hospital provision, "while not discriminatory in explicit terms, clearly operates 'to prevent recovery or collection by the United States.'" Pet. App. 8a. This is so because, "[w]hile the operation of this medigap provision would prevent recovery by VA hospitals, * * * it would almost always allow recovery to private hospitals." *Id.* at 8a-9a. Accord *Capital Blue Cross*, 992 F.2d at 1273 ("Congress' use of the word 'operate' manifests its intent not only to prohibit discrimination that appears o[n] the face of an agreement or a statute, but also discrimination that occurs in practice."). Such a result constitutes discrimination against the United States in violation of 38 U.S.C. 1729(f).

3. Petitioner finally argues (Pet. 12-14) that the court of appeals erred in holding that its right to contract was not constitutionally impaired, because the court mistakenly believed that enactment of 38 U.S.C. 1729 preceded issuance of the medigap policies. Petitioner asserts (Pet. 12-13) that "[i]n fact, Blue Cross wrote and issued the C Plus contract before Congress amended § 1729, effective April 7, 1986, to allow for payment under health plan contracts to the government."[8]

[8] Two sentences earlier, petitioner states (Pet. 12) that "the C Plus contracts issued between January 1, 1986 and 1990 were virtually unchanged" (footnote omitted). Whether or not contracts petitioner entered into with individual veterans after April 7, 1986 were "virtually unchanged" from (or indeed identical to) earlier contracts, there could be no contention that the Fifth Amendment would bar application of Section 1729 to such policies.

Even if BCBS wrote the medigap policies before Congress amended Section 1729, however, that Section applies to the policies if they were modified or renewed after the effective date of Section 1729's amendment. When Section 1729 was amended, Congress specifically addressed the amendment's application to pre-existing health plan contracts, and provided:

> In the case of a health-plan contract * * * that was entered into before [April 7, 1986] and which is modified or renewed on or after such date, the amendment * * * shall apply * * * with respect to care and services provided after such date of modification or renewal. * * * [T]he term 'modified' includes any change in premium or coverage.

Pub. L. No. 99-272, Tit. XIX, § 19013(b), 100 Stat. 385. Because petitioner did not address fully below any issues regarding the veterans' policies' effective dates, modifications or renewals, the record does not contain detailed information concerning those matters. See Pet. C.A. Br. 6-7; C.A. Record Excerpts. To the extent the record does address those concerns, however, it appears that the relevant policies were either entered into, modified or renewed following Section 1729's effective date.[9]

[9] Given common practices in the health insurance industry, it is virtually inconceivable that the policies were not renewed or the premiums altered before the veterans received the services at issue in this litigation. The record demonstrates that some of the applicable C Plus policies were entered into well after April 7, 1986, and suggests that the contracts were renewed on an annual basis each January 1. See C Plus with PMD, Medicare Supplemental Contract, Attachment 8 to Pl.'s Mot. for Summ. J. (noting effective date of January 1, 1988).

In any event, "[i]mmunity from federal regulation is not gained through forehanded contracts." *FHA* v. *The Darlington, Inc.*, 358 U.S. 84, 91 (1958) (citation and internal quotation marks omitted). Rather, "[s]o long as the Constitution authorizes the subsequently enacted legislation, the fact that its provisions limit or interfere with previously acquired rights does not condemn it." *Ibid.*[10] As the court of appeals noted, petitioner has not challenged the authority of Congress to "provide that the United States could not be discriminated against in the operation of such medical insurance plans." Pet. App. 9a.

~~renewed on an annual basis each January 1. See C Plus with PMD, Medicare Supplemental Contract, Attachment 8 to Pl.'s Mot. for Summ. J. (noting effective date of January 1, 1988).~~ The record also reflects, contrary to petitioner's suggestions (Pet. 12 & n.4), that the veterans received treatment at VA hospitals between mid-1987 and 1990. See Pet. App. 12a; C.A. Record Excerpts Tab 7, at 3-13 (Amended Complaint). Accordingly, the veterans' treatment most likely occurred during contracts effective after April 7, 1986 or following annual renewals or modifications of any policies BCBS wrote before April 7, 1986; in such circumstances, Section 1729, by its terms, unquestionably applies to the policies.

[10] As this Court explained in *Connolly* v. *Pension Benefit Guaranty Corp.*, 475 U.S. 211 (1986):

> Contracts, however express, cannot fetter the constitutional authority of Congress. Contracts may create rights of property, but when contracts deal with a subject matter which lies within the control of Congress, they have a congenital infirmity. Parties cannot remove their transactions from the reach of dominant constitutional power by making contracts about them.

Id. at 223-224 (quoting *Norman* v. *Baltimore & O.R.R.* 294 U.S. 240, 307-308 (1935)).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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